Petition

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

STATE OF NEW JERSEY,
Petitioner,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

IRWIN I. KIMMELMAN,
Attorney General of New Jersey,
Attorney for Petitioner, State of New Jersey,
Richard J. Hughes Justice Complex,
CN 112
Trenton, New Jersey 08625.
(609) 292-4919

JAMES J. CIANCIA,
Assistant Attorney General,
Of Counsel.

ANDREA M. SILKOWITZ,
Deputy Attorney General,
On the Petition.

Adams Press Corp., 5 Commerce Street, Newark, N. J. 07102—(201) 623-8611

Questions Presented

1. Does the Secretary of the United States Department of Health and Human Services and his delegatees, as did his predecessor, the Secretary of the Department of Health, Education and Welfare and his delegatees, have the statutory responsibility to provide, upon specific request by a state, correct and reliable interpretations of regulations which he has promulgated in order to assure a state's informed decision in formulating its state plan for a joint federal-state medical assistance program and the state's maximization of federal financial participation in its program so as to meet the costs of providing medical assistance to the needy?

2. Did the Court of Appeals err in extending the Court's decision in *Schweiker* v. *Hansen,* 450 U.S. 785 (1981) so as to preclude the State of New Jersey from filing an amendment to its State Old Age Assistance plan retroactive to 1971, where the Social Security Act neither compels nor addresses limitations upon implementation of plan amendments and the State's need to seek retroactive approval is directly and solely attributable to high-level Health, Education and Welfare representatives' failure upon repeated requests by the State to provide correct interpretations of ambiguous regulations?

3. Is this Court's *per curiam* decision in *Schweiker* v. *Hansen,* 450 U.S. 785 (1981) permissibly interpreted to require a showing of affirmative misconduct as a prerequisite for a state's estoppel of the federal government in the context of the formulation of a state plan for a medical or categorical assistance program?

4. Assuming that affirmative misconduct must be established as a precondition for estoppel of the federal government by a state, did the Court of Appeals err in

concluding that the facts of this case did not satisfy the prerequisites for establishing an estoppel defense?

5. Did the Court of Appeals err in concluding that Medicaid eligibility as established by 42 U.S.C. §1396a (a)(10)(A) was limited to those individuals who were eligible for direct cash payments, but not the equivalent services, made available under the State's Old Age Assistance program?

6. Did the Court of Appeals err in failing to construe the regulations governing financial eligibility for New Jersey's Medical Assistance for the Aged program as those regulations have been construed by the State agency which administered the program, and thereby improperly affirm the denial in part of the State's claim for federal financial reimbursement?

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October Term, 1981

STATE OF NEW JERSEY,
Petitioner,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Petitioner respectfully prays that a writ of certiorari issue to review that portion of the judgment and opinion of the United States Court of Appeals for the Third Circuit entered in this proceeding on February 5, 1982 which denied the petition for review of the decision of the Departmental Grant Appeals Board of the Department of Health and Human Services disallowing "federal reimbursement under the Medicaid program for medical services provided by the State over a two-year period to certain aged, institutionalized individuals" (App. A at 3a).

Opinions Below

The opinion of the United States Court of Appeals for the Third Circuit entered on February 5, 1982 is reported at 670 F.2d 1284 (3rd Cir. 1982) and is appended to this petition as Appendix A. The decision of the Departmental Grant Appeals Board was entered on August 8, 1980 and is appended to this petition as Appendix C. This decision of the Administrator of the Health Care Facilities Administration was entered on November 22, 1978 and is appended to this petition as Appendix D.

Jurisdiction

A petition for review of the August 8, 1980 decision of the Departmental Grant Appeals Board of the Department of Health and Human Services was filed with the United States Court of Appeals for the Third Circuit on October 3, 1980 pursuant to 42 U.S.C. §1316(a)(3) in that the Board's final determination constituted an adjudication of a plan conformity dispute within the scope of 42 U.S.C. §1396c.

The opinion and judgment of the Court of Appeals for the Third Circuit were entered February 5, 1982 with this petition for certiorari filed within 90 days of that date. This Court's jurisdiction to review a judgment of the Court of Appeals by writ of certiorari is therefore invoked pursuant to 28 U.S.C. §1254(1).

Statutes and Regulations Involved

The pertinent provisions of the regulations of the United States Department of Health, Education and Welfare (45 C.F.R. §§201.3(g) and 248.10), the Social Security Act of 1935, as amended (42 U.S.C. §1396a(a)(10)), the New

Jersey Financial Assistance Manual (sections 131, 201, and 412), and the Medical Assistance for the Aged Manual of Administration (sections 3321, 3322 and 315) are set forth in Appendix E.

Statement of the Case

By this petition the State of New Jersey seeks to obtain federal reimbursement under the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.*, for medical services provided from July 1971-October 1973 to certain indigent and aged individuals in approved long-term care facilities within the State. It is undisputed that these individuals would have been eligible under federal statutory and regulatory guidelines for Medicaid benefits. The Secretary of Health and Human Services however has denied the State's claim for over $12 million solely upon the finding of technical noncompliance of a related state plan provision. There exists no factual dispute that this plan noncompliance was occasioned by responsible Health, Education and Welfare* (hereinafter "HEW") officials' purportedly authoritative but erroneous interpretation of HEW regulations over the course of several years in the formative stages of adoption and implementation of New Jersey's Medicaid program.

Prior to January 1, 1970, needy elderly residents in the State of New Jersey with insufficient means to obtain necessary medical services (*viz.,* individuals or couples over 65 whose monthly income did not exceed $150 or $250 respectively) were eligible for both medical and basic maintenance benefits provided through the federally funded

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* The Department of Health, Education and Welfare has been redesignated the Department of Health and Human Services, with the Secretary succeeding to the responsibilities of administration of the Medicaid program. Pub. L. 96-88 §601.

Old Age Assistance Program (hereinafter "OAA"), N.J.S.A. 44:7-1 *et seq.* (L. 1936, c. 31), and the Kerr-Mills Program (Pub. L. 86-778, 74 Stat. 987; 42 U.S.C. §301 *et seq.*), adopted in New Jersey as the Medical Assistance for the Aged (hereinafter "MAA") program, N.J.S.A. 44:7-76 *et seq.* (L. 1962, c. 222). Eligibility for MAA medical benefits was also extended to certain needy individuals and couples 65 years of age or over who were financially ineligible for OAA benefits (See Medical Assistance for the Aged Manual of Administration §§ 3312 and 3322; Appendix E at 79a to 81a).

On July 30, 1965, Title XIX of the Social Security Act (Pub. L. 89-97, Title I, 79 Stat. 343) was enacted into law authorizing the appropriation of federal monies to enable states to provide medical assistance benefits to needy aged individuals with insufficient income and resources to meet the cost of necessary medical services. 42 U.S.C. §1396.* Although the Act did not require states

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* As enacted, participating states would be required to extend coverage to: persons receiving aid under categorical assistance programs, including OAA, 42 U.S.C. §1396a(a)(10)(A); 42 U.S.C. §1396a(a)(13)(B); to those who would be eligible for categorical benefits but for prohibited durational residence, age or citizen requirements, 42 U.S.C. §1396a(b)(1), (3) and (4); to those under twenty-one who would qualify for Aid for Families with Dependent Children if they were under eighteen, 42 U.S.C. §1396a(b)(2); and essential spouses of categorical assistance recipients living with such recipients and whose needs were considered in determining the amount of assistance, see 42 U.S.C. §1396d(a).

No additional groups of individuals were required to be provided for under a State Medicaid plan. See 45 C.F.R. §248.1(b). A state could, however, choose to extend benefits to additional categories of individuals: 1) one or more of the six designated groups set forth in 45 C.F.R. §248.10(b)(2) ("optional categorically needy") or; 2) individuals whose income exceeded financial eligibility levels established in the categorical assistance pro-

(Footnote continued on following page)

to establish these programs, considerable pressure to do so was ensured by the further provision that after December 31, 1969, federal funding for medical vendor payments under the OAA and Kerr-Mills Programs, as well as other public assistance programs, would be terminated. As specified in Title XIX, (42 U.S.C. §1396a(a)(10)(A)), (see Appendix E at 67a), automatic Medicaid eligibility would be afforded to persons receiving categorical assistance benefits, such as OAA. The eligibility of other aged poor groups, such as members of the MAA population with income in excess of OAA financial eligibility standards, however, was not addressed by the statute.

In consequence the New Jersey Legislature in 1968 began deliberations as to the enactment of a program consistent with Title XIX requirements, consulting with Regional HEW officials to assist them in these efforts. Of particular interest to the legislative bodies was their desire to transfer as many MAA recipients as possible to the Medicaid program in order to continue to receive federal financial participation in the costs of their care. See "Medical Care for Low Income Persons in New Jersey", A Report to the General Assembly of the State of New Jersey, dated September 10, 1968 (Record, pp. 258, 259, 267 and 268). In this regard, State Senator Maraziti

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(Footnote continued from preceding page)

grams, 42 U.S.C. §1396a(a)(10)(C) ("medically needy"). Unlike the optional categorically needy selection, where a state opted to extend benefits to any class of persons whose income exceeded one of the categorical assistance program eligibility levels, 42 U.S.C. §1396a(a)(10)(B) (1970 version) (See App. E at 67a to 68a) (current version at 42 U.S.C. §1396a(a)(10)(C)) obligated that state thereupon to extend benefits to "all individuals who would, except for income and resources" be eligible for any of the categorical assistance program benefits. These provisions have been substantially recodified at 42 C.F.R. §435.200 *et seq.* (optional categorically needy coverage) and 42 C.F.R. §435.300 *et seq.* (optional medically needy coverage).

contacted the Regional HEW Office in May 1968 for guidance in achieving this result. In response to Senator Maraziti's recommendation that the State transfer the entire institutionalized MAA population onto Medicaid, Regional HEW Commissioner James Callison commented:

> "It would appear to us that your proposal assumes that all such individuals in the described facilities would meet the needs requirement for OAA.
>
> "While this is a matter which is more appropriately a subject to comment by the responsible State agency than by this Department *I deem it important to call to your attention that New Jersey's MAA program currently provides nursing home care to individuals whose income and resources are in excess of the standard of need established by the State for OAA purposes.* It is clear that individuals cannot be covered under the State's OAA program unless they meet the eligibility requirements therefor. The proposal would have the effect of barring some persons now being served under the State's MAA program from coverage under the terms of the proposed State's Title XIX program.
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> * * *
>
> *"Should the State wish to include such individuals in its Title XIX plan, it would be required, by* virtue of *Section 1902(a)(10)(B),** *to provide for all categorically related persons who met the same standard of medical need."* Letter from James Callison to Joseph Maraziti dated May 22, 1968 (Pa 31).** (emphasis supplied)

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* See Appendix E at 67a to 68a.

** Pa as used hereinafter refers to the appendix filed by petitioner in the Court of Appeals proceeding.

By his citation of §1902(a)(10)(B), Commissioner Callison thus clearly specified that if Medicaid coverage was extended to the MAA population, New Jersey would be compelled to extend Medicaid coverage to all other individuals financially disqualified for the OAA categorical assistance program as well as the State's other categorical assistance programs, Aid to Families with Dependent Children (Title IV-A), Aid to the Blind (Title X), and Aid to the Permanently and Totally Disabled (Title XIV), *viz.* the "medically needy". See footnote p. 4 *supra.* Additional contact by State Welfare and Medicaid officials with both Regional and Washington-based HEW representatives and attorneys resulted in similar advice: that eligibility for Medicaid benefits for the MAA population could only be achieved by adoption of such a medically needy program. See Affidavit of William H. Metcalf (Pa34); Affidavit of William J. Jones (Pa44). See also Medicaid Prospectus Meeting Roster of Attendance, dated June 13, 1969 (Pa53). Tecla Kern, the HEW liaison prior to adoption of the State Medicaid program in 1970, has corroborated the content of the federal advice: namely, that the "[s]tate staff were informed that if the State wished to include the over 65 medically needy [the MAA population] it would have to include all categorically related groups." (Memorandum from Tecla Kern to Don Wortman dated July 2, 1976) (Pa52).

Additionally, Ms. Kern has conceded that not until October 1973 did she become aware of the HEW central office policy implemented in other regions of the country (apparently from the inception of the program) that allowed states to adopt a higher standard of OAA income eligibility for persons such as New Jersey's MAA population, institutionalized in nursing homes and other medical facilities, based upon their special needs (Pa52). The failure of Ms. Kern and other key federal officials to keep apprised of central office interpretations and to relay that information to New Jersey agencies program has been similarly conceded by former Regional HEW Commissioner Toby: "Regional Staff [prior to late 1973] . . . had not been aware that the special needs provision [formerly 45 CFR §248.10(b)(2)(ii) (see Appendix E at 69a to 70a),* now 42 C.F.R. §§435.231 and 435.1005] could be applied in determining the financial eligibility of this optional group [for OAA and thereby Medicaid benefits]." (Pa50). Thus, as interpreted consistently from 1968-1973 by HEW officials selected to assist New Jersey in formulating their initial State Medicaid plan, the provisions of then 45 C.F.R. §248.10(b)(2)(ii) which authorized optional Medicaid coverage for institutionalized persons "who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside . . ." permitted consideration for purposes of income eligibility only of the basic maintenance needs of this population and not of the additional costs of any special services (such as homemaker or attendant assistance) which they might require in the community.

In late 1969, petitioner State of New Jersey submitted for approval a State plan for services to be provided under a medical assistance program. This plan, which was approved and effective as of January 1, 1970, limited the program in accordance with the original State objectives to those individuals deemed categorically needy. Pursuant to then 45 C.F.R. §248.10(b)(2)(ii) New Jersey chose to include as a categorically needy group persons 65 years of age or older in institutions for tuberculosis or mental disease,

> "who, if they left such facility, would be eligible for financial assistance under New Jersey's ap-

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* 45 C.F.R. §248.10(b)(2)(ii) which was formally adopted on February 27, 1971 embodies the requirements and provisions governing the Medicaid program previously set forth in the Handbook of Public Assistance Administration. See 36 F.R. 3860 (February 27, 1971).

> proved plans for Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled. This includes persons in medical facilities who have enough income to meet their personal needs while in the institution but not enough to meet their needs outside the facility according to the appropriate plan." (New Jersey State Plan for Medical Assistance III (A)(2)(d)) (Pa41).

Consistent with the federal interpretations provided prior and subsequent to the inception of the program, state welfare officers construed this provision as establishing Medicaid eligibility for institutionalized individuals only in circumstances where they satisfied categorical conditions and where their income would be insufficient to meet basic maintenance needs in the community at the established monthly rate. Circular Letter No. 715 (Pa43). As a result, the overwhelming majority of institutionalized MAA recipients were considered ineligible for federally matched Medicaid benefits and thus were extended medical benefits solely at state expense.

From the inception of the State's Medicaid program, the State authorized the granting of OAA benefits both for basic maintenance needs ($162 per month) and special needs, such as homemaker or attendant services for persons in the community. Effective July 1, 1971, however, New Jersey modified its procedures in calculating the OAA assistance payment by adopting a comprehensive, flat grant, which eliminated the additional payment for homemaker services.* It retained, however, the alternative procedure recognized from January 1970 until the change-over, (see Categorical Assistance Budget Manual §315.1 (1969)) (Record at p. 212) *viz.*, the purchase by the county welfare boards through vendor payments of homemaker services. See also Financial Assistance Manual §412.1. (Appendix E at 77a to 78a).

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* While retaining an income eligibility level of $162 for skilled nursing facilities, a higher level of $170 was instituted for boarding home care. Thus, an individual's recognized needs for the latter care would include a living allowance of up to $150 per month plus a personal allowance of $20. Financial Assistance Manual §131 (Appendix E at 74a).

During the period prior to the adoption of the flat grant budget, HEW officials, who were apprised of the existence of the special circumstances component of the OAA grant, failed due to their ignorance of the Secretary's interpretation of his regulations, to apprise New Jersey officials of the State's entitlement to claim federal financial participation for institutionalized MAA recipients, who if released to the community, would have income less than the total of allowable basic and special needs (See memorandum from William Toby to Don Wortman, dated June 23, 1976 (Pa50)). As a consequence, New Jersey failed to submit claims for reimbursement for MAA recipients who had income in excess of the OAA basic needs eligibility level of $162, but less than the total of basic needs and the special needs component. Additionally, by reason of federal officials' misinterpretation of federal policy, the State was not apprised of the significance of the contemplated and ultimate adoption of the OAA flat grant for purposes of the Medicaid program.

In the fall of 1973, William H, Metcalf, Deputy Director of the New Jersey Division of Medical Assistance and Health Services, attended a conference in Charleston, West Virginia in which he was apprised that the central HEW office authorized the inclusion of the aged medically needy (such as the institutionalized MAA population) in a Medicaid program without the necessity of including other medically needy groups. This, he learned, could be accomplished by establishing a separate eligibility level for OAA institutionalized recipients embodying basic needs plus income required for special homemaker needs which would be provided in the community (Pa34a to Pa35). Following confirmation of this information, Maurice Kott, Acting Commissioner of the State Department of Institutions and Agencies, on November 12, 1973 submitted to the Regional HEW Office an amendment to the State plans for Titles I, X and XIV (the categorical assistance programs for the aged, blind and disabled), increasing the income eligibility standard for certain institutionalized adults to $510 monthly. See Transmittal No. 73-14 (Pa54). On December 10, 1973, the amendment was approved by William Toby, Acting Regional Commissioner, retroactive to October 1973. As a result, nearly all current recipients of MAA in nursing homes became eligible for Medicaid benefits, pursuant to Section III(A)(2)(d) of the Title XIX State Plan and 45 C.F.R. §248.10(b)(2)(ii) (Pa58).

On February 7, 1974, petitioner included in its submission of quarterly statement of expenditures for Title XIX for the period October through December 1974, a claim for federal financial participation (hereinafter "ffp") in the amount of $14,842,373 for institutionalized MAA patients for the period January 1970 through October 1973. By letter dated May 5, 1975, Elmer Smith notified Ann Klein, Commissioner of the then Department of Institutions and Agencies, that the State's claim for federal reimbursement under Title XIX for medical services provided institutionalized MAA patients for the 1970-1973 period was disallowed. By a series of letters the State requested reconsideration of the disallowance, pursuant to then 45 C.F.R. §201.4 (Record at pp. 14-22).

Upon review of the historical events preceding New Jersey's 1973 adoption of the Title I, X and XIV Plan amendments in his reconsideration of the disallowance, the new Regional Commissioner William Toby concluded that the disallowance was erroneous. In urging approval of the claim submitted for the period January 1, 1970 to July 1, 1971, Mr. Toby noted that the Region had previously mistakenly overlooked that eligibility for "financial assistance" during this period was not limited to the OAA income levels of $162, but included the additional sums necessary for satisfying special needs of the individual in the community, *e.g.*, homemaker and other support services (Memorandum from William Toby to Don Wortman, dated June 23, 1976) (Pa49 to Pa50). As to the second period following elimination of the special needs budgeting allowance, Mr. Toby concluded that Regional HEW staff, who assisted the State in adopting the OAA flat grant system and in establishing a Medicaid program "had not been aware that the special needs provision could be applied in determining the financial eligibility of this optional group . . ." (Pa50). In recognition of the Regional office's failure to have provided adequate advice to the State, Mr. Toby recommended that the "elimination of the special need provisions on July 1, 1971, [be viewed] as an accidental action so far as Title XIX was concerned, and . . . that in the interest of equity, the State should be permitted to remedy that error"* (Pa51).

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* Similar conclusions were noted in a memorandum submitted by Borge Varmer, Regional Attorney, to William Toby, Acting Regional Commissioner, SRS, in which Mr. Varmer recommended that New Jersey be granted federal financial participation (ffp) for the entire period in question (Pa41). Regarding the period following the adoption of the flat grant amendments and elimination of the special needs provisions (July 1, 1971 to September 30, 1973), Mr. Varmer concluded that the above modifications of New Jersey's Title I, X and XIV programs were effected "in error" and that since the State satisfied all other conditions for obtaining ffp for the MAA population, retroactive reinstatement of the special needs allowances should be authorized. This result, he concluded, would be consistent with federal law, since the services for which reimbursement was sought did not fall outside the scope of services for which the Social Security Act authorized payment of Title XIX monies.

On November 22, 1978, Leonard D. Schaeffer, Administrator of the Health Care Financing Administration (hereinafter "HCFA") of HEW, issued his decision upholding the disallowance of $14,842,373 in ffp claimed for services provided to the MAA population from January 1, 1970 through September 30, 1973 (See Appendix D).* Regarding the critical July 1971-October 1973 period, the Administrator rejected the recommendation of Regional Commissioner Toby and concluded that payment in accordance with the State's claim would be illegal on a twofold basis: (1) HEW was legally barred by Section 1903 (a)(1) of the Social Security Act [42 U.S.C. §1396b(a)(1)] from paying for services not covered under a state's approved Medicaid plan; and (2) the government could not be estopped from denying the claim under the facts presented (App. D at 63a).

On December 20, 1978, petitioner filed with the Departmental Grant Appeals Board of HEW an Application for Review of the November 22, 1978 decision by the HCFA Administrator (Pa20 to Pa29). In its decision of August 8, 1980 the Board affirmed the HCFA Administrator's decision. Although concluding that the State was not given accurate information by federal officials, it rejected the State's estoppel theory, construing the federal role in administering the Medicaid program as a passive one, "essentially limited to ensuring that the states [are] acting in accordance with . . . conditions set forth in [Title XIX]" (App. C at 44a to 45a). In this regard, the Board further ruled without citation to any specific statutory provision that it lacked authority to approve an amendment of the State's OAA plan retroactive to July 1971 to allow for a higher eligibility standard for the institutionalized as accomplished by the October 1973 amendment (App. C at 48a to 49a). Petitioner's additional contention that entitlement to federal Medicaid reimbursement existed under the State plans in effect in 1971-1973 based upon MAA recipients' eligibility for purchased homemaker services was rejected by the Board based upon its conclusion that 42 U.S.C. §1396a(a)(10)(A)'s reference to "aid or assistance under any plan of the State approved under Subchapter I, X, or XIV or XVI or part A of Subchapter IV" would not include homemaker and attendant services (App. C at 46a to 48a). And petitioner's final demonstration through its regulations that a higher income eligibility standard was utilized from 1971-1973 for institutionalized persons in need of boarding home care was summarily rejected by the Board (App. C at 49a to 50a).

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* The disallowance as to the period January 1, 1970 through June 30, 1971 was affirmed with the proviso that a revised claim with additional specified documentation could be submitted. The State subsequently submitted a revised claim for this period which was approved by the Secretary. Accordingly, the disallowance as it relates to the period January 1, 1970 to June 30, 1971 is not at issue herein. The total amount in dispute, therefore, is $12,142,452 (See App. A at 11a n. 10).

On October 6, 1980, petitioner filed a Petition for Review of the Board's August 8, 1980 decision with the United States Court of Appeals for the Third Circuit pursuant to 42 U.S.C. §1316(a)(3), construing the various determinations of the Board as an adjudication of a plan conformity dispute within the purview of 42 U.S.C. §1396.* The United States Court of Appeals in its opinion of February 5, 1982 rejected each of petitioner's contentions as to the invalidity of the disallowance. Thus, it determined that the State's provision subsequent to July 1971 of homemaker services to the MAA population, in lieu of the pre-July 1971 cash payments for such services, could not qualify as "aid or assistance" under OAA so as to establish Medicaid eligibility for the MAA population pursuant to 42 U.S.C. §1396a(a)(10)(A) (App. A at 20a to 23a). The Court of Appeals further summarily affirmed the Departmental Grant Appeals Board's decision (App. C at 49a to 50a) as to the appropriate MAA income eligibility standard to be utilized in establishing Medicaid eligibility, thereby rejecting the interpretation of State income eligibility regulations advanced by the State administrating agency (App. A at 32a). In rejecting petitioner's contention that respondent be estopped from disallowing the State's claim based upon its representatives' consistently erroneous responses to State officials' requests for assistance in establishing Medicaid eligibility for the MAA population, the Court concluded that HEW's actions neither rose to the level of "misrepresentation" nor "affirmative misconduct" so as to warrant acceptance of the estoppel defense (App. A at 26a to 28a). Similarly, it refused to accept the State's contention that as the fiduciary of Title XIX funds and promulgator of the program's governing regulations, HEW's failure to have rendered adequate assistance to the State in the formulation of its State plan necessarily thwarted congressional objectives of ensuring State adoption of an expansive medical assistance program (App. A at 28a to 31a). Rather, it concluded that HEW had no "legally enforceable obligation to provide advice and guidance to the states regarding the content of their Medicaid plans." (App. A at 31a). Finally, the Court rejected the State's contention that consideration of HEW's pivotal role in preventing New Jersey's formulation of the Medicaid coverage plan it desired as well as Title XIX objectives warranted waiver of HEW's regulation (45 C.F.R. §201.3(g)) precluding retroactive approval of a state plan amendment earlier than the initial date of the quarter in which the plan amendment was submitted (App. A at 31a to 32a) so as to permit implementation of New Jersey's November 1973 OAA plan amendment retroactive to July 1971.

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* Respondent thereafter filed a Motion to Dismiss the Petition for Review on jurisdictional grounds. By Order dated January 12, 1981, the Court referred the motion to the merits panel. In its opinion of February 5, 1982 (App. A at 11a to 17a), the United States Court of Appeals concluded, based upon its prior ruling in *State of New Jersey* v. *Department of Health and Human Services,* 670 F.2d 1262 (3rd Cir. 1981), that the instant petition was reviewable under 42 U.S.C. §1316(a).

ARGUMENT

The decision of the Court of Appeals which upheld the Secretary of Health and Human Services' refusal to waive the provisions of 45 C.F.R. §201.3(g) so as to permit the State of New Jersey to file a retroactive amendment to its Title I state plan should be reviewed by this Court since it presents signifiicant issues as to the Secretary's statutory responsibilities to states participating in programs of cooperative federalism and the appropriateness of extension of the Court's decision in *Schweiker* v. *Hansen* to the intergovernmental context.

This petition presents substantial issues of national importance not previously addressed by the Court relating to the federal government's statutory responsibilities to states participating in jointly state and federally funded categorical and medical assistance programs and states' corresponding ability to enforce those obligations in order to implement as fully as possible the policies and objectives of these assistance programs. Notwithstanding the key function of the Secretary of the United States Department of Health and Human Services like that of his predecessor the Secretary of the Department of Health, Education and Welfare as administrator of the Social Security programs and promulgator of regulations governing the complex eligibility and coverage requirements for these programs and the primary Congressional objective of enabling states through these federal appropriations to establish as expansive a scheme for coverage as possible, the Court of Appeals has concluded that Congress intended to impose no concomitant obligation upon the Secretary and high-level administrators to provide assistance to the states in comprehending and selecting the options available to them in the creation of medical and categorical assistance programs. The decision below sounds therefore, an unmistakeable signal to the Health and Human Services Secretary as well as all other federal administrative fiduciaries of federal funds to be dispensed to the states that they bear no responsibility to provide assistance of any sort to inquiring states. Their role as administrators of multi-billion dollar programs and the states' intended status as knowing participants in schemes of "cooperative federalism" are thus rendered mockeries.

Beyond embracing an absurdly limited theory of federal administrative responsibility in the context of cooperative federal-state programs, the Court of Appeals has espoused an equally circumscribed theory of estoppel so as to effectively preclude any possibility of successful assertion of such a defense under circumstances, such as here, where no fraud or ill motives can be ascribed to the federal government. Thus, the court below interjects as a conclusive factor the requirement that misrepresentation or wrongful concealment of some material fact have been made with the intention that the State rely to its detriment on the resulting misunderstanding (App. A at 26a to 27a). Imposition of such a heavy burden as a precondition for successful assertion of an estoppel defense certainly has never been demanded by this Court and is in conflict with more flexible concepts of equitable estoppel, requiring only that there be conduct amounting to a representation of material facts, known or necessarily imputed to be known which is intended or will naturally have the result that it will be acted upon by the other party. See *United*

States v. *Georgia-Pacific Company,* 421 F.2d 92, 96-97 and n.4 (9th Cir. 1970); 3 Pomeroy, *Equity Jurisprudence,* §805 at 191-192 (5th ed. Symons 1941). See also Note, Equitable estoppel of the Government, 79 *Colum. L. Rev.* 551, 562-563 (1979). Additionally, despite this Court's careful limitation of its *per curiam* decision in *Schweiker* v. *Hansen,* 450 U.S. 785 (1981) to the facts of that case and clear disinclination to determine what conduct would be sufficient to estop the government in cases such as the matter *sub judice,* where substantive legislative requirements regarding eligibility for Social Security benefits would not be voided if the estoppel defense were to succeed, the Court of Appeals has concluded that a "faithful application of *Schweiker* v. *Hansen,* . . . compels the conclusion that New Jersey has failed to identify a factual predicate sufficient to estop an agency of the government from carrying out its statutory responsibilities" (App. A at 28a). To the contrary however it is evident that by permitting the Health and Human Services Secretary to deny Medicaid reimbursement for medical services provided a class of individuals indisputably eligible under federal statutory guidelines based solely upon Health and Human Services' refusal to extend its policy of approval of retroactive plan amendments beyond the legislatively unmandated three month period, the Court of Appeals has thwarted, rather than advanced Congressional objectives.

A. The Secretary of the Department of Health and Human Services and his delegatees have an affirmative obligation to provide reliable interpretations of ambiguous regulatory provisions to inquiring states in order to facilitate their formulation of plans for categorical and medical assistance programs consistent with their needs and resources.

This Court in a series of decisions beginning with *King* v. *Smith,* 392 U.S. 309 (1968) and concluding with *Harris* v. *McRae,* 448 U.S. 297 (1980) has addressed various questions arising under the categorical and medical assistance programs established and partially funded by Congress regarding the scope of state discretion in limiting eligibility and coverage. While many of these decisions have affirmed state prerogative to fashion special programs consistent with significant state policies and fiscal conditions, see *e.g., Harris* v. *McRae, supra, Quern* v. *Mandley,* 436 U.S. 725 (1978), *Beal* v. *Doe,* 432 U.S. 438 (1977), *New York Dep't of Social Services* v. *Dublino,* 413 U.S. 405 (1973), this Court has never suggested that the resulting diversity of programmatic elements among the various state plans somehow renders the federal role in these "cooperative" ventures any less significant or the need for the states to be able to intelligently consider and choose their options for eligibility and coverage, and ultimately their very participation in these programs, any less compelling. Indeed in a related context in *Pennhurst State School & Hospital* v. *Halderman,* —— U.S. ——, 101 S. Ct. 1531 (1981) this Court has emphasized the necessity for state comprehension of its obligations and options under a federally funded program and the federal administrating agency's corresponding responsibility to make clear the extent of these obligations prior to state election to participate in the program.

The decision below however by confounding the potential exercise of state discretion with state omniscience of unarticulated federal policies renders a mockery of the concept of "cooperative federalism." Thus the Court has concluded that despite high level federal officials' ignorance of the Secretary's interpretation of an obscure Medicaid regulation, the absence of any corresponding provision in the Social Security Act, and federal officials' failure to apprise New Jersey in response to continued inquiries as to its ability to extend Medicaid coverage for the MAA population without a concomitant provision of these benefits to other "medically needy" groups, as is required by 42 U.S.C. §1396a(a)(10)(C), New Jersey retained the ability to exercise its discretion by submitting a state plan provision embodying the unknown and novel eligibility scheme (App. A at 30a n.18). Obviously however the equation of intelligent consideration and election of options with the possibility for conceptualization of a heretofore unknown eligibility scheme denigrates the status of the state as a partner with the federal government and denies to the state the opportunity for reflection and knowing participation demanded by Congress and recognized by this Court in *Pennhurst State School & Hospital* v. *Halderman, supra.*

So too the Court of Appeals' determination thwarts the effectuation of additional and significant objectives of Congress in enacting these social welfare programs. Thus, its conclusion that the Secretary's role as administrator and promulgator of regulations governing a program which has been characterized as "a morass of bureaucratic complexity," *Herweg* v. *Ray,* — U.S. —, —, 102 S. Ct. 1059 (1982) (Burger, C.J., dissenting) does not impliedly create any corresponding responsibility to provide reliable assistance to states formulating their initial state plans (App. A at 29a-30a) further eviscerates the concept of the federal-state partnership and renders meaningless the Secretary's obvious function as an interpreter of the Act and mentor to participating states. Moreover by relegating the state to the uncertain status of clairvoyant, the Court has frustrated the state's ability to achieve Title XIX's "primary objective", *Beal* v. *Doe, supra* at 444 of "enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance [to] individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. §1396.* As a consequence, monies specifically earmarked for the type of services made available to institutionalized MAA recipients and for that very population itself, the elderly poor, have been denied to petitioner, thereby necessarily thwarting the state's ability to exercise its discretion in developing a medical assistance program in accordance with reasonably received needs of its indigent communities.**

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* That Congress envisioned the Secretary's function vis à vis the states to be an affirmative one with the intended purpose of enabling states to maximize federal financial participation in their programs is made evident by 42 U.S.C. §1312, which provides in pertinent part

> "[I]n order to assist the States *to extend the scope and content,* and improve the quality of medical care and medical services . . . the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content and quality of medical care for the use of the States . . ." (emphasis supplied)

** The Court of Appeals' narrow and erroneous reading of the Social Security Act is further evident in its conclusion that the MAA population's eligibility for OAA homemaker and attendant services (see Financial Assistance Manual §412.1, App. E at 77a to 78a) would not qualify as receipt of "aid or assistance under any plan of the State approved under Subchapter I [OAA] . . ." so as to establish eligibility for Medicaid benefits pursuant to 42 U.S.C. §§1396a (a) (10) (A) and 1396d (a) (App. A at 21a to 22a). Contrary to the Court of Appeals' suggested reading, 42 U.S.C. §1396a(a)(10)(A) does not limit Medicaid eligibility to receipt of "assistance" *i.e.,* "money payments," see 42 U.S.C.

(Footnote continued on following page)

(Footnote continued from preceding page)

§306(a) (repealed 1974) under a state categorical-assistance plan. Rather, Medicaid eligibility is expressly extended to recipients of both *"aid* or assistance" under the OAA plan, a definition obviously of sufficient breath to encompass homemaker and other directly purchased services for OAA recipients. Moreover, the distinction urged by the Court of Appeals is as a practical matter a meaningless one in the context of establishing Medicaid eligibility. Prior to petitioner's amendment of its State Plans under Titles I, X and XIV and adoption of a comprehensive, flat grant in July 1971, OAA recipients with special needs were provided homemaker or other services either through an allowance to the recipient or a vendor payment on behalf of the client. (*See* Categorical Assistance Budget Manual §315.1 (Record at p. 212). With the elimination of the individual computation of the OAA grant, petitioner continued to provide for payments for homemaker services but limited the manner in which the services could be obtained to direct purchase of services by the county welfare board. See Financial Assistance Manual §412.1 (App. E at 77a to 78a). Thus, the assistance for which the MAA population would have been eligible during the two periods in which the aid was dispensed is identical. One, the court below maintains, is sufficient for purposes of establishing Medicaid eligibility; the other, it maintains, is not. The mere difference in the manner in which these services were reimbursed, petitioner submits, however, is insufficient to bar the payment of funds claimed, especially under the unique circumstances of this case.

Finally, to the extent that it declined to give any deference to the interpretation of state financial eligibility requirements advanced by the state agency responsible for administration of the State's MAA program (See Appendix A at 32a) the Court of Appeals abdicated its reviewing responsibilities, *cf. New York Department of Social Services* v. *Dublino,* 413 U.S. 405, 421 (1973) and consequently erred in rejecting petitioner's claim that HHS had utilized too low a financial eligibility cut-off for establishing MAA recipients' eligibility for OAA and concomitantly Medicaid benefits. (See Financial Assistance Manual §§131(a) and (b) and 201(d)(1)-(10), App. E at 74a to 77a).

B. Where the Secretary of the Department of Health, Education and Welfare has breached his statutory obligation to provide accurate interpretations of ambiguous federal Medicaid eligibility regulations over a course of several years in response to specific and repeated state inquiries as to eligibility of an identifiable population and where it is undisputed that the identified population satisfies all substantive requirements for Medicaid eligibility and has established eligibility for a nearly identical state medical assistance program, the objectives of the Medicaid program can only be effectuated if retroactive plan approval extending Medicaid coverage to the population is granted.

While considerations, among others, of a need for deference to enactments of coordinate branches of government and avoidance of unreasonable burdens upon administrative officials, have resulted in this Court's cautionary review of estoppel defenses raised against the federal government, this Court has declined to address the appropriateness of the estoppel defense except as it pertained to the factual circumstances of the particular matter *sub judice*. See *e.g., United States Immigration & Naturalization Service* v. *Hibi,* 414 U.S. 5 (1973), *Federal Crop Ins. Corp.* v. *Merrill,* 332 U.S. 380 (1947). Moreover, and of particular import here, is the absence of any characterization by this Court of the conduct necessary to establish an estoppel defense generally or specifically as in this case where substantial legislative requirements regarding eligibility for Social Security benefits would not be abnegated if the estoppel defense were to succeed.

Thus, "faithful application of *Schweiker* v. *Hansen*" does not, as the Court of Appeals concluded, "compel" (App. A at 28a) a rejection of New Jersey's estoppel argument.* Unlike *Schweiker,* where a lower echelon Social Security representative failed to comply with a non-binding agency policy, here high-level federal representatives delegated the responsibility to assist New Jersey in the formulation of its Medicaid program,** violated their statutory obligation by affirmatively and erroneously representing in response to specific inquiries as to the eligibility of the MAA population for Medicaid benefits that such eligibility could only be established if New Jersey were to extend benefits to all other "medically needy" groups. As a consequence federal officials similarly could not and did not apprise New Jersey of the significance for purposes of receipt of federal reimbursement of opting to retain or eliminate the individually computed benefit scheme and adopting a flat grant approach.

Moreover, unlike *Schweiker,* state officials herein reasonably relied on these high-level officials' representations by reason of: their positions in the HHS bureauacracy; the obscure language of the pertinent regulation

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* The Court of Appeals misconstrues *Schweiker* v. *Hansen* as imposing in a case such as this the requirement that "affirmative misconduct" by a federal official be established in order to prevail as to the estoppel defense. Even were this Court to conclude that such a showing must be made herein, petitioner submits that federal officials' repeated violation of their affirmative statutory responsibility to provide accurate interpretation of federal law, see Point A *supra,* constitutes such "affirmative misconduct."

** 45 C.F.R. §201.3(c) adopted on July 29, 1970 (35 F.R. 12180) and amended on September 26, 1974 (39 F.R. 34542) delegates to the Regional Commissioner the "Authority to take affirmative action on State plans and amendments thereto on the basis of policy statements or precedents previously approved by the Administrator." Implicit in this authority is the obligation to consult with and to advise states as to requirements and options established by federal law.

(45 CFR §248.10(b)(2)(ii), and the absence of any corresponding statutory provision or knowledge of any similar regulatory scheme. They thus could not reasonably have been expected to understand the significance of their elimination of the OAA special needs provision or their entitlement to seek federal reimbursement from 1971-1973. In *Schweiker,* in contrast, the failure to advise of the option of a precautionary filing of the written application or the erroneous suggestion of ineligibility for benefits did not preclude such a filing and indeed the facts failed to establish the petitioner's ignorance of the use of written applications as a precondition for obtaining benefits.

The most critical distinction however between *Schweiker* and the instant case and the one most tellingly ignored by the Court of Appeals is the fact that acceptance of petitioner's estoppel defense would not undermine any Congressional policies, but rather would serve to advance significant legislative objectives. Thus, whereas the granting of retroactive benefits in *Schweiker* despite the failure to file a timely written application would be violative of the legislative requirement that benefits not be extended in the absence of a "filed application," in the instant matter it is undisputed that payment of the state's claim would not be violative of any substantive conditions of eligibility imposed by Congress. Indeed the services provided and the population affected are precisely those for which federal Medicaid monies have been earmarked. Additionally, to permit the retroactive filing of New Jersey's OAA state plan amendment would not be violative of any Congressional policy, since the Act is silent as to the desireability of approval or disapproval of retroactive amendments. Nor would a retroactive filing be violative of any administrative policy since the Secretary's regulations recognize the need for same. The only bar to such a filing is the time limitation which the Secretary has adopted. Under the circumstances of this case however where federal governmental action alone has prevented full compliance with the Secretary's time limitations, and where substantial Congressional objectives would be advanced, waiver of the three month limitation of 45 C.F.R. §201.3 (g) is equitably compelled.* See *United States* v. *Wharton,* 514 F. 2d 406 (9th Cir. 1975); *Brandt* v. *Hickel,* 427 F.2d 53 (9th Cir. 1970); Note, *supra* 79 *Colum. L. Rev.* at 560, 565-567, 571.

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* Alternatively, the circumstances detailed above similarly suggest that the State's elimination of its OAA special needs computations and adoption of a flat grant scheme in 1971 as a direct consequence of federal officials' failure to act in accordance with their statutory responsibilities of providing competent advice to the State, denied the State the "opportunity to make an intelligent election" of its options, thereby precluding the imposition of the sanctions mandated by 45 C.F.R. §201.3(g). See *Moser* v. *United States,* 341 U.S. 41, 47 (1951).

CONCLUSION

For the above stated reasons, it is respectfully submitted that this petition for a writ of certiorari to the United States Court of Appeals for the Third Circuit should be granted.

Respectfully submitted,

Irwin I. Kimmelman,
Attorney General of New Jersey,
Attorney for Petitioner, State of New Jersey,
Richard J. Hughes Justice Complex,
CN 112
Trenton, New Jersey 08625.
(609) 292-4919

James J. Ciancia,
Assistant Attorney General,
Of Counsel.

Andrea M. Silkowitz,
Deputy Attorney General,
On the Petition.

[Appendices Follow]

Appendix

APPENDIX A

Opinion of the United States Court of Appeals for the Third Circuit

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 80-2438

STATE OF NEW JERSEY,
Petitioner

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent

ON PETITION FOR REVIEW OF A DECISION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Argued Thursday, October 29, 1981

Before: ADAMS, ROSENN, and SLOVITER, *Circuit Judges*

(Filed February 5, 1982)

JAMES R. ZAZZALI
Attorney General of New Jersey
Trenton, New Jersey

Of Counsel:
ERMINIE L. CONLEY
Assistant Attorney General

On the Brief:
ANDREA M. SILKOWITZ (Argued)
Deputy Attorney General
Attorneys for Petitioner

AMY YOURMAN
Office of the General Counsel
Department of Health and
Human Services
Washington, D.C.

NANCY M. P. KING (Argued)
Office of the General Counsel
Department of Health and
Human Services
Baltimore, Maryland
Attorneys for Respondent

OPINION OF THE COURT

ADAMS, *Circuit Judge*.

The State of New Jersey petitions from a decision of the Grant Appeals Board of the Department of Health and Human Services (HHS) which denied federal reimbursement under the Medicaid program for medical services provided by the State over a two-year period to certain aged, institutionalized individuals. New Jersey contends that the Board erred in four respects: first, by concluding that the State's Medicaid plan in effect for the period in question did not cover the individuals with respect to whom New Jersey seeks reimbursement; second, by holding that HHS was not estopped from insisting on the disallowance by reason of allegedly inaccurate and misleading advice Department officials furnished to the State; third, by refusing to allow the State to revise its Medicaid plan retroactively in order thereby to become eligible for federal assistance; and fourth, by miscalculating the amount of the disallowance ultimately imposed. After determining that we have jurisdiction under 42 U.S.C. §1316(a) to entertain this appeal, we reject each of the contentions advanced by New Jersey and deny the petition for review.

Appendix A

I

A

Title XIX of the Social Security Act, 42 U.S.C. §1396, provides for the appropriation of federal monies to enable each state, "as far as practicable under the conditions in such State," to furnish medical assistance and rehabilitation services to certain individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. §1396. A state is not obliged to participate in what is commonly referred to as the "Medicaid" program. If it chooses to do so, however, it must submit to and have approved by the Secretary of HHS[1] a "State plan" that satisfies various statutory and regulatory requirements. *Id.* at §1396a(a) & (b). Once such a plan has been approved and takes effect, a state is entitled to federal grants representing reimbursement for a portion of the expenditures it incurs in providing specified medical services to eligible persons under the plan. *Id.* at §1396b; *see* 45 C.F.R. §201.5. No reimbursement is available for any amounts paid by a state to or on behalf of any "ineligible individuals." 42 C.F.R. §447.59(b).

At the time New Jersey entered the Medicaid program,[2] Title XIX required, among other things, that a state plan extend medical assistance to all "categorically needy" individuals — that is, to "all individuals receiving aid or assistance" under any of a number of that state's income-assistance programs, such as the Old Age Assistance program.[3] In addition, a state, at its option, could also provide Medicaid coverage to those persons referred to as "medically needy" — that is, to individuals who had "income and resources" in excess of the various eligibility ceilings for any of the public-assistance programs, but insufficient to meet "the costs of necessary medical or remedial care and services."[4] Under the terms of the

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[1] Many of the programs administered by the former Department of Health, Education, and Welfare (HEW), including Medicaid, were transferred in 1979 to the newly-established Department of Health and Human Services (HHS). This opinion will refer in all instances to HHS, even though many of the events discussed herein occurred while HEW was still in existence.

[2] New Jersey's Medicaid plan took effect on January 1, 1970, after several years of planning. The expenditures for which the State seeks reimbursement cover the period from July 1, 1971, through September 30, 1973. Consequently, the success or failure of New Jersey's reimbursement claim depends, to a large extent, on the interpretation of statutes and regulations in effect for the period *prior* to 1974. A number of these statutes and regulations have been amended at some point after the events occurred with which this

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NOTE *(Continued)*

opinion is concerned. For example, Titles I, X, XIV, and XVI of the Social Security Act, mentioned in note 3 *infra*, were replaced in 1974 by the Supplemental Security Income program, Pub. L. No. 92-603, 86 Stat. 1465 (1972), codified at 42 U.S.C. §§1381-1385. For the reader's convenience, reference will be made to the current version of Title XIX whenever possible, but no attempt will be made to discuss or explain this version.

[3] In relevant part, §1902 of the Social Security Act, 42 U.S.C. §1396a(a)(10) (1970 version) (current version at 42 U.S.C. §1396a(a)(10)(A)) required that a state plan

> provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I [Old Age Assistance], X [Aid to the Blind], XIV [Aid to the Permanently and Totally Disabled], and XVI [Supplemental Security Income for the Aged, Blind, or Disabled], and part A of title IV [Aid to Families with Dependent Children].

[4]

> [I]f medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any [state plan, such as Title I, X, XIV, XVI, or IV-A] and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, [the state Medicaid plan must] provide (i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care and services. . . .

42 U.S.C. §1396a(a)(10)(B) (1970 version) (current version at 42 U.S.C. §1396a(a)(10)(C)).

statute, if a state elected to create a "medically needy" program, it was obligated to extend coverage to "*all* medically needy groups that correspond to the covered categorically needy groups," 45 C.F.R. §248.10(b)(5) (1976 ed.) (emphasis added) (current version at 42 C.F.R. §§435.300-.325). Thus, for example, a state that provided Medicaid assistance to "categorically needy" persons participating in the Old Age Assistance and the Aid to the Blind programs could not include in its plan the "medically needy" aged without simultaneously including any "medically needy" blind persons with similar financial and non-financial characteristics. 42 U.S.C. §1396a(a)(10)(B) (1970 version) (current version at 42 U.S.C. §1396a(a)(10)(C)).

Pursuant to regulations that accompanied Title XIX, a state was empowered to include within its Medicaid plan certain individuals, not classifiable as either "categorically needy" or "medically needy" in their own right, who nonetheless qualified for coverage because they were members of one of six so-called "optional categorical groups." *See* 45 C.F.R. §248.10(b)(2) (1976 ed.) (current version at 42 C.F.R. §§435.200-.231).[5] For purposes of this appeal, only one such "optional categorical group" need be mentioned. Medicaid reimbursement could be obtained, if a state so desired, for medical services provided to

> [p]ersons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs

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[5] Individuals eligible under these optional coverage provisions were treated, for Medicaid purposes, as "categorically needy." *See* 42 C.F.R. §435.1(b)(2) (describing the conditions for Medicaid eligibility that existed prior to the 1972 amendments to the Social Security Act *(see* note 2 *supra)*).

> outside the facility according to the appropriate State plan. . . .

45 C.F.R. §248.10(b)(2)(ii) (1976 ed.) (current version at 42 C.F.R. §435.211).

B

With this general statutory and regulatory background in mind, we proceed to discuss the facts involved in this particular appeal. Before it joined the Medicaid program, New Jersey provided benefits through a state-administered Medical Assistance for the Aged (MAA) program to elderly residents who lacked sufficient means to obtain necessary medical services. *See* 44 N.J. Stat. Ann. §§7-76 *et seq*. (West). New Jersey included in the MAA arrangement certain elderly persons who had income and resources in excess of the OAA eligibility limits.[6] The present controversy involves the status of this group of individuals — persons ineligible for OAA who nonetheless participated in the State's MAA program — under the New Jersey Medicaid scheme that became effective in January 1970.

The Medicaid plan ultimately adopted by New Jersey and approved by the Secretary of HHS did not purport to provide Medicaid coverage for all individuals who previously had been receiving MAA assistance. Former

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[6] Regulations established by the Commissioner of the Department of Institutions and Agencies provided that

> individuals 65 years of age, financially ineligible for OAA benefits but whose income was between $150 and $500 [per month], would qualify for reimbursement under the MAA program for hospital and home health care. . . . Single persons whose monthly income did not exceed $410 would also qualify for assistance for nursing home care. . . . Married couples whose monthly income was between $250 and $600 would qualify for hospital and home health care benefits and if between $250 and $650, for nursing home assistance. . . .

Brief for Petitioner at 2 (citations omitted).

MAA recipients who qualified for federal OAA payments were, of course, incorporated into the State's plan by reason of being "categorically needy," *see* 42 U.S.C. §1396a(a)(10) (1970 version) (current version at 42 U.S.C. §1396a(a)(10)(A)). Those members of the MAA population with income and resources in excess of OAA standards, however, were intentionally excluded from Medicaid coverage by the State. Apparently, New Jersey officials believed, for reasons discussed in Part III(B) of this opinion, that if such individuals were included within its Title XIX plan, then the State would be obligated to extend Medicaid benefits to *all* similarly-situated "medically needy" individuals financially disqualified from categorical-assistance programs.[7] Rather than enact such an extensive and far-reaching "medically needy" program,[8] New Jersey decided to forego any attempt to bring OAA-ineligible MAA recipients within the scope of its Medicaid plan, and instead chose to continue to provide medical assistance to such persons at its own expense. Grant Appeals Board Decision No. 115 (Aug. 8, 1980), Appendix at 3a.

Aside from covering "categorically needy" persons, though, New Jersey extended Medicaid assistance to members of the "optional categorical group" defined by Regulation 248.10(b)(2)(ii), *supra*, that is, to those individuals who had "enough income to meet their personal needs" as long as they remained within a medical or intermediate care facility, but who would have qualified for some sort of categorical assistance, such as OAA, had they left the institution. In connection with this aspect of New Jersey's program, during the period from January 1, 1970, through June 30, 1971, the financial standard employed by the State in determining eligibility for its categorical assistance programs took into account the applicant's "special needs." As explained by the Grant Appeals Board, individuals with "incomes in excess of the basic monthly standard of need . . . could [nonetheless] be eligible for public assistance benefits if their income were below the financial limit augmented to include . . . special circumstance items . . . essential for the physical health and safety of persons in specified situations." Grant Appeals Board Decision, *supra*, Appendix at 4a. One such "special circumstance item" authorized a non-institutionalized OAA client to receive a cash or vendor payment for "homemaker services." *See* New Jersey Categorical Assistance Budget Manual §315.1; Record at 212. Effective July 1, 1971, however, New Jersey amended its Medicaid plan by eliminating the "special needs" arrangement and, therefore, the homemaker cash payment. Instead, from that date until September 30, 1973, the State admeasured eligibility for OAA aid by means of a "flat grant" test. Under this latter approach, "[t]he income standard against which institutionalized individuals' incomes were to be compared for purposes of establishing Medicaid eligibility [under Regulation 248.10(b)(2)(ii)] was a set monetary level that remained constant irrespective of any special needs that an individual might have if he were residing in the community." Grant Appeals Board Decision, *supra*, Appendix at 4a.

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[7] Specifically, New Jersey asserts that its officials were of the opinion that, were the State to extend Medicaid coverage to the entire MAA population, it would be compelled to sweep within its Medicaid program "all other individuals financially disqualified for the OAA categorical assistance program, as well as [those disqualified from] the State's other categorical assistance programs, [*viz*] Aid to Families with Dependent Children (Title IV-A), Aid to the Blind (Title X) and Aid to the Permanently and Totally Disabled (Title XIV)." Brief for Petitioner at 5.

[8] Indeed, New Jersey still does not include the "medically needy" within its Medicaid program. *See* Record at 188; Brief for Respondent at 6.

In the fall of 1973, administrators in New Jersey's Division of Medical Assistance and Health Services learned, apparently as the result of discussions with Medicaid officials from other states, that many of the

OAA-ineligible persons who formerly had been receiving MAA benefits could in fact have been brought within New Jersey's Medicaid arrangement, even without the State's adoption of a comprehensive "medically needy" program. This desired result could be achieved, New Jersey discovered, by extending Medicaid coverage to the "optional categorical group" set forth in Regulation 248.10(b)(2)(ii) and by defining the eligibility standard for OAA aid to include "special needs" such as homemaker services. Under such a configuration, elderly institutionalized individuals who did not receive OAA could nonetheless be covered under Medicaid because: (1) if those individuals were to leave their institutions, they would be unable to afford necessary homemaker services; (2) such individuals would thus be unable "to meet their needs outside the facility"; (3) consequently, they would qualify for OAA payments "according to the appropriate State plan," *viz.*, a Title I plan with a "special needs" standard of eligibility; and (4) they could then be covered under Medicaid as members of the "optional categorical group" defined by Regulation 248.10(b)(2)(ii).

Effective October 1, 1973, New Jersey amended its Medicaid plan to incorporate the above-described arrangement. That is, the State replaced its "flat grant" method of determining OAA eligibility with a "special needs" standard that took into account the cost of homemaker services. The result of this amendment was that "virtually all" of those institutionalized individuals to whom New Jersey had provided MAA benefits at its own expense from January 1970 to October 1973 became eligible for federally funded Medicaid assistance. Letter from G. Riti, Acting Director, Division of Public Welfare, N.J. Department of Institutions and Agencies (Nov. 13, 1973), Appendix at 58a-59a.

In February 1974, New Jersey filed with HHS a retroactive claim for reimbursement of $14.8 million under the Medicaid program for medical services provided, at the State's expense, from January 1970 to October 1973, to OAA-ineligible MAA recipients. In May 1975, the agency's Regional Commissioner denied New Jersey's claim on the ground that the individuals with respect to whom New Jersey sought federal financial assistance had not been covered under the various State Medicaid plans in effect prior to October 1973. In November 1978, the portion of the Regional Commissioner's decision covering the July 1971 to October 1973 period, when New Jersey used a "flat grant" Title I calculation scheme, was upheld by the Administrator of the Department's Health Care Financing Administration. At the same time, however, the Administrator ruled that the State — assuming proper documentation was forthcoming[9] — could receive reimbursement for that fraction of the $14.8 million disallowance relating to the January 1970 to July 1971 period. The Administrator reasoned that during these initial months, New Jersey's Medicaid plan in fact contained the two elements necessary to trigger Medicaid coverage for institutionalized MAA recipients, namely, Regulation 248.10(b)(2)(ii) and a "special needs" provision in the OAA program. Letter from L. Schaeffer, Administrator, HCFA (Nov. 22, 1978), Appendix at 12a-19a. After further administrative proceedings not relevant to this appeal, at which State officials furnished the documentation discussed in note 9, *supra*, New Jersey was given credit for disallowances entered for the January 1, 1970, to June 30, 1971, interval.[10]

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[9] The Administrator concluded that, on the basis of the evidence before him, he could not be sure that the State was requesting reimbursement only with respect to individuals who qualified under the "special needs" formula, and only for services provided by long-term care facilities that met federal standards for Medicaid provider participation. He suggested that New Jersey submit a revised claim that incorporated such documentation. Letter from L. Schaeffer, Administrator, HCFA (Nov. 22, 1978), Appendix at 17a-18a.

New Jersey appealed the Administrator's affirmance of the July 1, 1971, to September 30, 1973, disallowance to the HHS Grant Appeals Board. After concluding that a full-scale evidentiary hearing was unnecessary, because there was no genuine dispute between the parties as to the facts, the Board resolved all contested legal issues in favor of HHS and upheld the agency's disallowance determination. Grant Appeals Board Decision, *supra*, Appendix at 2a-11a. Shortly thereafter, New Jersey filed a petition for review with this Court, asserting that jurisdiction existed under 42 U.S.C. §1316(a), and asking that the decision of the Board be reversed.

II

Before addressing the merits, we must determine whether this Court is authorized under the relevant statutes to entertain New Jersey's petition for review of the Grant Appeals Board order. HHS urges that this appeal be dismissed for want of initial appellate-level jurisdiction. In addition, the Department contends that in any event the State has failed to exhaust all available administrative remedies. Both the jurisdictional and the exhaustion arguments advanced here by HHS were considered at length and ultimately rejected by this Court in a recent decision involving these same two parties, *State of New Jersey v. Department of Health and Human Services*, Nos. 80-2809 et al. (3d Cir. Dec. 23, 1981). We conclude, consistent with the reasoning and the holding of *State of New Jersey*, that the controversy at bar is justiciable by this Court at the present time.

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[10] New Jersey initially sought Medicaid reimbursement totaling $14,842,373. This amount was later modified to include an additional $139,317, for a total of $14,981,690. *See* Letter from A. Klein, Commissioner, New Jersey Department of Human Services (Mar. 27, 1980), Record at 451-53. The State subsequently received notification that it would be credited for $2,839,238 with respect to the January 1970 to July 1971 period. *See* Brief for Respondent at 14 n.5. Thus, the remaining disallowance assessed against New Jersey totals $12,142,452. It is this latter sum that is at issue in the present appeal.

A

The relevant provisions of the Social Security Act establish two distinct procedures for judicial review of final determinations by the Secretary of HHS. Any state dissatisfied with the Secretary's refusal to approve its Title XIX plan, or an amendment thereto, is authorized to bring an immediate appeal to "the United States court of appeals for the circuit in which such State is located." 42 U.S.C. §§1316(a) & (b). Direct review by a court of appeals also is available whenever the Secretary concludes, "after reasonable notice and opportunity for hearing," that a state's Medicaid plan, either on its face or in its administration, "has been so changed that it no longer complies with" applicable federal statutes and regulations. *Id.* at §1396c. Where the Secretary makes no finding with respect to plan-disapproval or plan-nonconformity, but instead simply "disallows" a state's request for reimbursement of "any item or class of items" deemed by the Secretary not to be eligible for federal financial participation under the Act, a petition addressed to a court of appeals would appear not to be in order. Rather, in such a situation, an aggrieved state's proper recourse, according to HHS, is first to request administrative reconsideration of the disallowance, *id.* at §1316(d), and then to seek judicial review in a federal district court.[11] *See State of New Jersey, supra*, slip op. at 11-17.

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[11] It is an open question, at least in this circuit, whether a disallowance entered by the Secretary after reconsideration under 42 U.S.C. §1316(d) is reviewable by a district court or, for that matter,

In view of our recent decision in *State of New Jersey*, it is unnecessary once again to discuss in detail the meaning, applicability, and interrelationship of section 1316(a) plan-conformity review and section 1316(d) disallowance review. For present purposes, it is sufficient to note that in *State of New Jersey*, this Court refused, when considering the section 1316 jurisdictional question, to be bound by the label that the Secretary attached to the agency's administrative activity. That is, we declined

> to adopt an approach which would permit the Secretary to foreclose judicial review under section 1316(a) in situations where one administrative route is pursued when another would be more appropriate. HHS, for example, should not be entitled to categorize as a "disallowance" what, in essence, amounts to a determination that a state's . . . program does not conform to a federally mandated requirement . . . . [I]n deciding whether section 1316(a) or section 1316(d) procedures are applicable, a court of appeals is obligated . . . to conduct an independent evaluation of the underlying substance of the dispute.

Slip op. at 18.

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by any other court. *See State of New Jersey, supra*, slip op. at 15-16. While HHS in past instances contended that §1316(d) orders should be immune from judicial scrutiny, *see* County of Alameda v. Weinberger, 520 F.2d 344, 347-49 (9th Cir. 1975) (rejecting such a contention), the Department has abandoned this position. *State of New Jersey, supra*, slip op. at 16 & n.8. In the present matter, for example, HHS has represented that "[i]f this Court determines to dismiss [this action] for lack of jurisdiction, there is no barrier to review in the district court of the Secretary's final disallowance determination . . . [T]he Secretary will not challenge the jurisdiction of the district courts to review disallowance determinations." Posthearing Submission for Respondent at 1.

Instructed by *State of New Jersey*, we consider the facts of the present matter as they relate to the jurisdictional issue. We believe that the differences between HHS and New Jersey "raise difficult and significant legal issues," *id.* at 20, having to do with the coverage of certain individuals under the Medicaid program, the estoppel of a federal agency for its allegedly misleading advice to state officials, and the ability of a state retroactively to alter provisions of its Social Security plan so as to maximize its receipt of federal dollars. To be sure, the Secretary in this instance has not explicitly rejected New Jersey's Medicaid plan or an amendment thereto, determined that the State's approved plan is being improperly administered, or threatened to terminate all future Medicaid payments to the State. Nonetheless, recognizing that "the present problem does not fall neatly under either [the disallowance or plan-conformity] category," *Solomon v. Califano*, 464 F. Supp. 1203, 1208 (D. Md. 1979), we conclude that "[t]he administrative determination about which New Jersey complains would appear to resemble more a finding of overall noncompliance with federal requirements," reviewable under section 1316(a), than "a technical, audit-connected shortcoming," appropriate for resolution under section 1316(d). *State of New Jersey, supra*, slip op. at 25.

In arriving at this conclusion, we are guided by the opinion of the Court of Appeals for the Fifth Circuit in a case with a factual background strikingly similar to that of the present appeal. In *Texas Department of Public Welfare*, 556 F.2d 326 (5th Cir. 1977), *cert. denied*, 439 U.S. 818 (1978), HHS defended its decision to "disallow" $92 million in Social Security claims submitted by Texas on the grounds that some of the expenditures for which the State sought reimbursement were "not covered or purchasable under an approved State Plan," while others were requested for a fiscal year during which "State . . . plans were not in operation with respect to the claimed expenditures." *Id.* at 331. Judge Ainsworth, writing for a unanimous panel, rejected HHS' contention that, because the Department had chosen to classify the reimbursement-denials as "disallowances," the judicial review provisions of section 1316(d) were applicable. Instead, he concluded, jurisdiction at the court of appeals level existed because the case in essence involved "attempts by Texas DPW to make material changes in the operation of [its] public service plan." As such, the State was entitled to receive the same administrative and judicial treatment as would be accorded a state that desired to amend its Social Security plan in a more straightforward (*i.e.*, a non-retroactive) manner: the plan-conformity procedures set forth in section 1316(a). *See* 42 U.S.C. §1316(b). Only these procedures would ensure that Texas' "substantial" claim was not treated "in a summary manner" by HHS officials. 556 F.2d at 331-32.

Here, as in *Texas Department of Public Welfare*. the agency's "disallowance" was premised on a determination that the expenditures claimed by New Jersey were not "covered" under the state Medicaid plan then in effect. Here, as in *Texas Department of Public Welfare*. HHS rejected an effort by the State retroactively to amend that plan to receive federal assistance for services provided during an earlier fiscal year to persons with respect to whom the plan was "not in operation." Consequently, here, as in *Texas Department of Public Welfare*. we believe that "the purposes of the Act and the equities are best served by treating this [matter] as a plan-conformity dispute under section 1316(a)." 556 F.2d at 330. *See also State of New Jersey, supra*, slip op. at 20-26; *Solomon v. Califano, supra*, 464 F. Supp. at 1208.

In this connection, we decline to accept HHS' claim that "[t]he case at hand involves a typical disallowance." Memorandum in Support of Respondent's Motion to

Dismiss at 14. The "disallowance"-type precedents relied on by the Department, in our view, simply are not apposite.[12] Similarly, we cannot agree with the agency's assertion that the question presented for review here arose as the result of "an isolated and highly focused inquiry" in the course of "[a] simple audit review." *Id.* at 14, 18. On the contrary, as New Jersey points out, both the complicated legal nature and procedural history of this dispute, discussed earlier, tend to belie any such argument. We also disagree with the Department's suggestion that New Jersey's request for a hearing under 45 C.F.R. §16.8(b)(2), which provides an opportunity for a party challenging a disallowance to present oral testimony to the Grant Appeals Board, constitutes an admission that, throughout the course of the administrative proceedings below, the State believed that a disallowance-type problem, as opposed to a plan-conformity issue, was involved. *See* Brief for Respondent at 18-20. This argument is unconvincing. From the outset of the controversy, the Secretary advised the State that the denial would be treated as a disallowance, a full opportunity for an on-record proceeding was provided before the

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[12] The dispute here between New Jersey and the Department cannot be traced to a mere "clerical" problem, such as the overpayment of physicians held to be appropriate for section 1316(d) resolution in State of Georgia, Department of Human Resources v. Califano, 446 F. Supp. 404 (N.D. Ga. 1977). Nor does this case concern only a discrete aspect of the State's Social Security plan, as in Wingate v. Harris, 501 F. Supp. 58, 63 (S.D.N.Y. 1980) (dispute involves only three decertified nursing homes, "not 'plan conformity' ") or State of Washington, Department of Social and Health Services v. Schweiker, No. 81-7414 (9th Cir. Sept. 29, 1981). Similarly, the crux of the present controversy has nothing to do with the "accuracy of an audit," *see* Medical Services Administration v. United States, 590 F.2d 135 (5th Cir. 1979). Finally, the facts of this appeal are not comparable with those present in *County of Alameda, supra* note 11 ("disallowance" where state requested reimbursement using erroneous formula). For a more thorough consideration of these cases, see *State of New Jersey, supra*, slip op. at 23-26.

Board anyway, and the State never acknowledged or endorsed the Secretary's characterization of the dispute as a disallowance.

Finally, we are not dissuaded from our conclusion that section 1316(a) procedures are appropriate for this matter by HHS' claim that, given such an outcome, "there would be no cases in which a disallowance of federal reimbursment under the Medicaid program could not be treated as a [plan]-compliance issue." Memorandum in Support of Respondent's Motion to Dismiss at 18. As we stressed in *State of New Jersey*:

> [We do not] wish to imply that *any* administrative disallowance can be reviewed directly in this Court as long as the protesting state asserts that the disallowance "really" raises compliance-related questions. We do not, after all, resort to such legal legerdemain in this case. Rather, we have independently reviewed the substance of the particular dispute involved here, and have concluded that the question of plan conformity lies at the heart of the claims of which New Jersey seeks review. It is precisely for this reason that §1316(a) review can be justified.

Slip op. at 29 n.12. In sum, we hold that a court of appeals has jurisdiction under 42 U.S.C. §1316(a) to consider, in the first instance, plan conformity-related determinations of the Grant Appeals Board of the type presented here for review by New Jersey.

B

As it did in *State of New Jersey*, HHS argues here that "by bringing this appeal now rather than insisting that a plan-conformity hearing be held pursuant to 42 U.S.C. §1316(a)(2), New Jersey has failed to exhaust its administrative remedies." *State of New Jersey, supra*, slip op. at 29. According to the Department, such a failure in the present case is fatal, inasmuch as the absence of a compliance hearing means that "there are no findings of fact by the Secretary which this Court can review." Brief for Respondent at 18.[13]

We disagree, primarily for the reasons we identified in *State of New Jersey*. In that decision, we noted that "[o]ur Court has recognized that, '[a]s a judicially created doctrine, the requirement of exhaustion has traditionally been waived' in those situations where 'exhaustion [would be] futile.' " *State of New Jersey, supra*, slip op. at 30, quoting *Susquehanna Valley Alliance v. Three Mile Island Nuclear Reactor*, 619 F.2d 231, 245 (3d Cir. 1980), *cert. denied*, 449 U.S. 1096 (1981). Applying this principle, we concluded that forcing the State to return to HHS for further administrative proceedings would indeed be "futile," given that there existed "no factual dispute between the parties that might be resolved by additional testimony or hearings," that "nothing in the record . . . even remotely indicates that the Secretary might adopt any other position were the case to be remanded for a compliance hearing," and that "none of the general justifications of the exhaustion doctrine . . . appears relevant in the situation at bar." *State of New Jersey, supra*, slip op. at 30-31.

The posture of the present appeal, we believe, is virtually identical with that in *State of New Jersey* with respect to the futility-of-exhaustion question. The Grant Appeals Board specifically found that "[t]here does not appear to be a genuine dispute as to the factual content of evidentiary material submitted for consideration" by the parties, that the only "disagreement" was "as to the import of the information and the conclusions to be drawn therefrom," and that therefore "there [was] no need for" the evidentiary hearing requested by the State pursuant to 45 C.F.R. §16.8(b)(2). Grant Appeals Board Decision, *supra*, Appendix at 5a-6a. In view of these declarations on the part of the Board, we are not persuaded by HHS' aforementioned argument that this appeal should be dismissed because "there are no findings of fact by the Secretary." We believe, moreover, that sufficient opportunity has been afforded both parties over a period of years to advance their legal contentions and accompanying documentation. Paraphrasing *State of New Jersey*, there is nothing in the record that "even remotely indicates" that the Secretary or the State might introduce any additional evidence or adopt any other legal position "were the case to be remanded for a compliance hearing." Were we convinced that a decision on the merits here would "premature[ly] interfere[ ] with agency processes," hinder the exercise of administrative "experience and expertise," or prevent the "compil[ation of] a record which is adequate for judicial review," *Weinberger v. Salfi*, 422 U.S. 749, 765 (1975), we of course would be bound to return this matter to HHS for further proceedings. We are unable to reach any such conclusions, however. Furthermore,

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[13] In a related argument, the Department contends that a plan-conformity hearing, described by 42 U.S.C. §1316(a)(2) and 45 C.F.R. §§213.1-.33, is a necessary predicate for direct appellate-level review, and that the present appeal should therefore be remanded so that such a hearing can be conducted. We cannot agree. We find nothing in the Act or its legislative history that precludes our treating the Grant Appeals Board's action on behalf of the Secretary in this dispute as a "final determination" rendered after an "opportunity for hearing" sufficient to satisfy the requirements of 42 U.S.C. §1396c and thereby vest jurisdiction in this Court under 42 U.S.C. §1316(a)(3).

> [a]s a practical matter, given the uncertainty that accompanies any attempt to administer a statute or regulation under attack in the courts, and given the amount of money involved, it should be in the interest of HHS, no less than in the interest of New Jersey, to have the present controversy resolved with all due haste.

State of New Jersey, supra, slip op. at 28. We therefore hold that New Jersey's "failure" to exhaust available administrative remedies, if indeed the State's action can be characterized as such, does not constitute a bar to our review of the merits of this appeal.

III

Having ascertained that New Jersey's petition for review defines a justiciable controversy, we proceed to consider the merits of this dispute. New Jersey contends that the Grant Appeals Board erred in four respects. For the reasons that follow, we find each of the State's arguments wanting.

A

New Jersey claims that the MAA individuals to whom it provided medical services at its own expense during July 1971 to October 1973 actually were covered by the State's Medicaid plan then in effect. The State's argument proceeds along these lines: (1) From January 1970 to July 1971, New Jersey's OAA plan contained a "special needs" provision. As a result of the interplay of this provision and Regulation 248.10(b)(2)(ii), *supra*, institutionalized MAA recipients who did not receive OAA cash payments were nonetheless eligible for Medicaid on the theory that, were such individuals to leave their institutions, they would receive OAA assistance so that they might purchase "special needs" such as homemaker services. (2) Effective July 1971, New Jersey replaced the "special needs" provision with a "flat grant" standard for determining OAA eligibility. The only practical consequence of this change was that members of the MAA population who left their institutions would no longer receive direct OAA payments in order to purchase homemaker services. Rather, such services were obtained indirectly; *i.e.*, homemaker services initially were contracted for by local welfare agencies, and then were made available to eligible individuals upon their request.[14] (3) Because "the assistance for which the MAA population would have been eligible during the two periods in which [homemaker services] aid was dispensed [was] identical," HHS' refusal to accept the latter arrangement as sufficient for Medicaid purposes "effects a meaningless distinction . . . . The mere difference in the manner [of reimbursement] is insufficient to bar the payment of [Medicaid] funds claimed [by the State]." Brief for Petitioner at 32-35.

We reject New Jersey's suggestion that nothing of import transpired when the State abandoned the "special needs" formula for determining OAA eligibility and substituted in its place a "flat grant" approach. On the contrary, prior to July 1, 1971, an aged individual whose income and resources exceeded the nominal OAA ceiling could nonetheless receive *cash* payments if he or she required homemaker services and was otherwise unable to pay for them. After that date, however, because homemaker services were provided through the auspices of county welfare boards, such an individual was no longer eligible for *cash* assistance in recognition of his or her special needs. The significance of New Jersey's elimination of the possibility of direct cash payments to MAA recipients for homemaker services becomes apparent when considered in connection with two provisions of the Social Security Act. Medicaid coverage was extended automatically only to "individuals receiving aid or assistance" under a state categorical-assistance plan, such as the Old Age Assistance program. 42 U.S.C. §1396a(a)(10) (1970 version) (current version at 42 U.S.C. §1396a(a)(10)(A)). And "old age assistance" was defined to include only "*money* payments to . . . needy individuals who are 65 years of age or older." 42 U.S.C. §306(a) (repealed 1974) (emphasis added).[15] In other words, according to the Act, only persons who received "money payments" could be said to be recipients of OAA "aid or assistance," and therefore only such persons qualified for "categorically needy" treatment under the Medicaid statute. Applying this principle, it is clear that, from January 1970 to July 1971, institutionalized MAA recipients were covered under New Jersey's Medicaid program because such persons were eligible for "aid or assistance" under the State's OAA plan in the form of "money payments" for homemaker services. From July 1971 to October 1973, however, the possibility of "money payments" for homemaker services ceased. We conclude, therefore, that after July 1971, members of New Jersey's MAA population were not eligible for "aid or assistance" under the State's OAA plan and thus were not within the scope of New Jersey's Medicaid program.

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[14] According to New Jersey's Financial Assistance Manual, §412.1, effective July 1, 1971, homemaker services were to be purchased

> by direct contractual arrangement and payment . . . between the County Welfare Board and the community agency furnishing approved homemaker services or an individual who is mutually acceptable to the eligibile unit and the County Welfare Board. Such purchase may be made for a person or persons for whom illness, death or other disruption in normal family living has [made] homemaker service . . . essential.

Brief for Petitioner at xix.

Indeed, as the Grant Appeals Board observed, it would be difficult to reconcile any contrary conclusion with the overall Medicaid statutory scheme. New Jersey contends that no meaningful distinction can be drawn between the post- and pre-July 1971 periods because the indirect provision of homemaker services through local welfare agencies is no less a form of "aid or assistance," within the meaning of 42 U.S.C. §1396a(a)(10), than is the direct disbursement to eligible persons of cash earmarked for such services. Homemaker services, however, are only one type of optional social services that a state is permitted to make available, in connection with its OAA plan, both to OAA recipients and non-recipients alike.[16] Acceptance of New Jersey's argument would mean that individuals who benefited not only from homemaker services, but also from any of the other optional social services provided by the State, would be deemed recipients of "aid or assistance" and would therefore be covered under Medicaid — despite the fact that many of these individuals did not qualify for OAA cash assistance. We decline, however, to "require as a matter of law that medical assistance be furnished to anyone," however financially well-endowed, who "receiv[es any] optional services under [any of a state's categorical-assistance] plans," Grant Appeals Board Decision, *supra*, Appendix at 9a. We believe, following the Board, that "when [s]ection [1396a(a)(10)] speaks of making medical assistance available to all individuals receiving aid or assistance under any plan of the State, . . . it is referring [only] to the 'categorically needy.' " *Id.*

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[15] In relevant part, 42 U.S.C. §306(a) provided that "the term 'old-age assistance' means money payments to, or . . . medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older . . . ." The reference to medical and remedial care ceased to have definitional import once the Medicaid program became operational. *See* Pub. L. No. 89-97, §121(b), 79 Stat. 286, 352 (1965), codified at 42 U.S.C. §1396b (note).

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[16] 42 U.S.C. §303(a)(4)(A)(ii) & (iii) authorized a state to provide in conjunction with its OAA plan a wide range of optional services, designed to reduce or prevent the dependency of persons who were or were likely to become OAA recipients. *See* 45 C.F.R. §222.55 (1976 ed.) (identifying various groups to whom optional services could be furnished). Such optional services — which included, in addition to homemaker services, the provision of, *inter alia*, day care, companionship, educational, financial, recreational, consultant, and legal services, *see* 45 C.F.R. §§222.55.-61 (1976 ed.) — were classified as "costs of administration" of a state's OAA program, and accordingly were reimbursable by the federal government to a lesser extent than ordinary OAA cash-assistance expenditures. *Compare* 42 U.S.C. §303(a)(4)(A) *with* 42 U.S.C. §303(a)(1).

B

New Jersey maintains that, even if institutionalized MAA recipients were not included within the terms of its Medicaid plan from July 1971 to October 1973, HHS nevertheless should be estopped from denying the requested reimbursement. In essence, the State claims that it did not extend Medicaid coverage to MAA individuals because it relied on erroneous advice disseminated to it by representatives of the Department.

In support of its estoppel argument, New Jersey points to the following evidence in the record: (1) In 1968, when New Jersey's Medicaid plan was being drafted, an HHS Regional Commissioner notified the State that it could not expect to transfer its entire institutionalized MAA population to the Medicaid rolls because that population included "individuals whose income and resources are in excess of the standard of need established by the State for OAA purposes." The Commissioner cautioned that "[s]hould the State wish to include such individuals in its Title XIX plan, it would be required, by virtue of [42 U.S.C. §1396a(a)(10)(B)], to provide for all categorically related persons who met the same standard of medical need." Letter from J. Callison (May 22, 1968), Appendix at 30a-33a. (2) In a 1976 affidavit, an official responsible for the State's Medicaid effort averred that "[d]uring all of my years with the New Jersey Medicaid Program, representatives from [HHS] never advised us that any part of the MAA population could be transferred to the Medicaid rolls so as to qualify for federal funding — [i]ndeed, it was always my understanding that [HHS] had advised us that no such transfer could be made." Affidavit of W. Metcalf, Deputy Director, Division of Medical Assistance and Health Services, N.J. Department of Institutions and Agencies (Apr. 6, 1976), Appendix at 34a-39a. (3) In a companion affidavit, a second State official stated that he had been advised "that there was no way that the MAA population could be transferred to [Medicaid] unless New Jersey adopted a medically indigent program." Affidavit of W. Jones, Superintendent, Hudson County Meadowview Hospital (Apr. 6, 1976), Appendix at 44a. (4) An HHS official who served in 1970 as liaison to New Jersey recalled that "State staff were informed that if the State wished to include the over 65 medically needy it would have to include all categorically related groups." The official conceded that she was "unaware that if a State included a special needs allowance in its Welfare Plans certain groups would be eligible for Medicaid." Memorandum of T. Kern, Senior Medical Services Specialist, HHS (July 2, 1976), Appendix at 52a. (5) In 1976, after reviewing the available evidence, an HHS Acting Regional Commissioner recommended that New Jersey's claim for reimbursement be honored "in the interest of equity." In arriving at this recommendation, the Commissioner stressed the fact that "[t]he option whereby the State could have extended Title XIX coverage to a majority of the . . . MAA caseload was apparently never pointed out by anyone [at HHS]," and the fact that HHS officials "failed to recognize and point out [the] significance" of New Jersey's conversion from a "special needs" to a "flat grant" OAA eligibility approach. Memorandum of W. Toby (June 23, 1976), Appendix at 49a-51a.

New Jersey concludes from this evidence that the record "clearly establishes" that "responsible federal regulators," demonstrably unable to decipher "obscure and unfathomable" statutes and regulations, "unwitting[ly]" misinformed and misled State officials with respect to the incorporation of the MAA population into the Medicaid program. The State contends that in light of "the unique federal-state relationship created by Title XIX," in view of the State's "unavoidable reliance upon . . . federal expertise," and in order "to prevent manifest injustice," HHS should be barred, on equitable grounds, from punishing New Jersey for any "technical noncompliance" with statutory requirements. Brief for Petitioner at 1, 27; Reply Brief for Petitioner at 7-8.

We find New Jersey's estoppel argument unpersuasive. Even if it were clear as a legal matter that estoppel could be invoked against the federal government, we would still be obliged to conclude that the State does not make out a compelling estoppel claim, given the particular facts present here.[17] This Court recently declared that

> [t]he party asserting estoppel must show more than that he was ignorant about some matter. Among the more important requirements of estoppel are that the party to be estopped has misrepresented or wrongfully concealed some material fact and that this party acted with the intention that the asserting party rely to his detriment on his misunderstanding.

United States ex rel. K&M Corp. v. A&M Gregos, Inc., 607 F.2d 44, 48 (3d Cir. 1979); *see also Consolidated Express, Inc. v. New York Shipping Association, Inc.*, 602 F.2d 494, 510 (3d Cir. 1979), *vacated and remanded on other grounds*, 448 U.S. 902 (1980). Nothing in the evidentiary material proffered by New Jersey indicates that federal officials "misrepresented" or "wrongfully concealed" information about the Medicaid statute "with the intention" that the State rely "to [its] detriment" on the resulting "misunderstanding." New Jersey cannot show — and, indeed, does not attempt to show — that HHS specifically instructed the State that MAA individuals could not be covered under Title XIX even if a "special needs" requirement were to be adopted. Similarly, New Jersey does not demonstrate — and, for that matter, does not attempt to demonstrate — that HHS directly advised the State that nothing of significance would follow from the replacement of a "special needs" with a "flat grant" standard for determining OAA eligibility. To be sure, State officials were informed (for example, by Commissioner Callison) that they could not expect to make Medicaid benefits available to "medically needy" elderly persons without simultaneously extending coverage to other, similarly-situated "medically needy" individuals. In view of 42 U.S.C. §1396a(a)(10)(B), however, this information, far from constituting a "misleading" assertion, was correct. If anything, HHS might be faulted for failing to advise the State that it could achieve its desired result by adopting a "special needs" formulation for use in conjunction with Regulation 248.10(b)(2)(ii). In our view, however, this "fault" — if it can be characterized as such — hardly rises to the level of "misrepresent[ation]" and "wrongful[ ] conceal[ment]" sufficient under *United States ex rel. K&M Corp.* to justify recognition of a defense of estoppel.

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[17] In view of our resolution of this "factual" question, it is unnecessary for us to decide whether, as a matter of law, estoppel is available against HHS in this case. In passing, we note that it is true, as New Jersey stresses, that the modern trend diverges somewhat from the doctrinaire position, announced in earlier cases, that estoppel could not be invoked against the government. *Compare* United States v. Lazy FC Ranch, 481 F.2d 985 (9th Cir. 1973) *with* Federal Crop Insurance Corp. v. Merrill, 332 U.S. 380, 384 (1947); *see* Note, *Equitable Estoppel of the Government*, 79 Columbia L. Rev. 551 (1979). It is arguable, however, that many of the "modern-trend" cases are not reconcilable with language contained in the Supreme Court's recent decision in Schweiker v. Hansen, 450 U.S. 785 (1981) (see especially footnote 4).

In arriving at our conclusion that the incidents described by New Jersey do not satisfy the factual threshold necessary for a successful estoppel claim, we have been guided by traditional notions as to the elements of estoppel, derived from cases such as *United States ex rel. K&M Corp.* involving two or more private litigants. The Supreme Court has recently intimated, however, that where estoppel is asserted against the federal government, a more exacting factual showing may be mandatory. In *Hansen v. Harris*, 619 F.2d 942 (2d Cir. 1980), the Second Circuit estopped HHS from denying Social Security benefits to a claimant who did not apply for them after being told, erroneously, by a representative of the Department that she was ineligible. The Supreme Court summarily reversed. *Schweiker v. Hansen*, 450 U.S. 785 (1981). Despite the urgings of the two dissenting Justices, *id.* at 791-92, the Court declined to define precisely "what type of conduct by a Government employee will estop the Government from insisting upon compliance with valid regulations." *Id.* at 788. The majority did determine, however, that the behavior of the employee under review — which the Second Circuit concluded did not amount to "affirmative misconduct," 619 F.2d at 948 — " 'fal[ls] far short' of conduct which would raise a serious question whether [HHS] is estopped from insisting upon compliance" with the agency's application requirement. *Id.* at 790. And in the course of canvassing both its own and various lower federal court decisions where the estoppel-against-the-government issue had been considered, the Court made it clear that it remained an open question whether a showing "even [of] 'affirmative misconduct' " would justify a claim of estoppel. *Id.* at 788. With respect to the present dispute, HHS was not guilty of some sort of "affirmative misconduct" when it allegedly misinformed or failed to inform New Jersey about the possibility of Medicaid coverage for the MAA group. A faithful application of *Schweiker v. Hansen*, therefore, compels the conclusion that New Jersey has failed to identify a factual predicate sufficient to estop an agency of the government from carrying out its statutory responsibilities.

New Jersey insists that, with respect to the transaction under review, HHS violated its "fiduciary" responsibility to aid the State in establishing "as expansive a [Medicaid] program as possible." Brief for Petitioner at 21-22. More specifically, New Jersey contends that

> [HHS] has an affirmative duty to assist the states in developing as inclusive a program as possible with the aid of Federal funds, . . . [that] Title XIX is remedial legislation and [therefore should] be given liberal interpretation, . . . that [the State] could not be expected to understand and apply [Regulation 248.10(b)(2)(ii)] without special guidance from Federal officials, . . . [and that] by denying [its] claim for [reimbursement], [HHS] thwarts the State's discretion to develop a medical assistance program to meet its needs and undermines the framework of cooperative federalism since the State can no longer rely on Federal expertise.

Grant Appeals Board Decision, *supra*, Appendix at 6a-7a.

In advancing this conglomerated attack, New Jersey appears to misperceive the relative responsibilities placed on a participating state and on the federal government in connection with a "cooperative" endeavor such as Medicaid. It bears repeating that there is no uniform, nationwide Medicaid plan per se: a state is not required to participate in the Title XIX program. To the extent it chooses to do so, it is free to fashion its own Medicaid arrangement, consistent with certain statutory requirements, *see* 42 U.S.C. §1396a(a), and subject, as previously mentioned, to the approval of the Secretary, *see id.* at §1396a(b). *See Harris v. McRae,* 448 U.S. 297, 301 (1980). It is the state that determines how much medical assistance it is "practicable" to provide in view of "the conditions in [the] State," 42 U.S.C. §1396; it is the state that initially decides which optional groups, if any, will be brought under its Medicaid umbrella, *see id.* at §1396a(a)(10); it is the state that actually administers whatever plan is ultimately adopted, *see id.* at §1396a(a)(4) & (5).

By contrast, the federal role, at least with respect to the direct formulation and implementation of a State's Medicaid plan, is more limited. To be sure, the Secretary is responsible for ensuring that such a plan, both on its face and in its administration, conforms to statutory mandates, *see* 42 U.S.C. §§1396a(b) & 1396c; and of course, the federal government has promised to bear a substantial percentage of "the total amount expended . . . as medical assistance under the State plan," *id.* at §1396b(a)(1). We find nothing in Title XIX or its legislative history, however, that obligates HHS to take all reasonable efforts to ensure that a state receives its maximum possible share of federal Medicaid dollars. For that matter, New Jersey has directed us to no case imposing financial liability upon HHS for its "failure" as a "fiduciary" either to investigate fully the "conditions" existing in a particular state or to advise officials of that state with respect to the drafting or the amendment of their Medicaid plan. Federal officials "are not privy to the various policy considerations which determine the scope of a State plan and cannot be expected to anticipate problems which might result from the State's implementation of its plan." Grant Appeals Board Decision, *supra*, Appendix at 8a.[18]

We do not make light of the difficulties confronted by state officials attempting to come to grips with "this complicated statute," *Beal v. Doe*, 432 U.S. 438, 447 (1977). Nor do we suggest that HHS' vast reservoir of expertise and resources is unavailable to Medicaid planners in the various state governments. We are not prepared to hold, however, that the federal government has a legally enforceable obligation to provide advice and guidance to the states regarding the content of their Medicaid plans. Accordingly, we reject New Jersey's estoppel-based argument.

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[18] In the proceeding below, the Grant Appeals Board also noted that

> [i]f a state has any doubt whether it is entitled to [federal reimbursement], it may submit a claim and receive an official Agency determination. Likewise, if a state has a question whether any group may be properly included within the state plan, it may include the group and receive an official Agency determination whether such inclusion conforms with the statutory requirements. In both instances, there are review and appeal rights which the state may pursue.

Grant Appeals Board Decision, *supra*, Appendix at 8a. The Board concluded, therefore, that "even if New Jersey was misinformed" by HHS, in view of these alternatives "the State was not diligent in protecting its interests." *Id.*

C

New Jersey contends that, in any event, it should be permitted retroactively to amend its Medicaid plan in order to qualify for federal financial participation for medical services provided to MAA recipients during the July 1971 to October 1973 period. The State correctly observes that nothing in the Social Security Act directly bars the Secretary from accepting such an amendment.

New Jersey's proposed course of action is explicitly prohibited by administrative regulation, however. Specifically, 45 C.F.R. §201.3(g) stipulates that the effective date of an amendment that makes new groups eligible for assistance or services provided under the approved state plan "may not be earlier than the first day of the calendar quarter in which [such an amendment] is submitted." New Jersey urges that we "waive" this "purely procedural" restriction. We decline to do so for three reasons. First, we find nothing in the Act or any of its accompanying regulations that would authorize us to create such a waiver. In a somewhat analogous situation, the Supreme Court refused to "waive" the requirement that individuals file a written application for Social Security benefits. According to the majority, "[a] court is no more authorized to overlook the valid regulation requiring that applications be in writing than it is to overlook any other valid requirement for the receipt of benefits." *Schweiker v. Hansen*, *supra*, 450 U.S. at 790. Second, we are convinced that the prohibition of retroactive plan amendments contained in Regulation 201.3(g) serves a useful purpose. As the Grant Appeals Board observed, if

New Jersey were now permitted to alter its former Medicaid plan in order officially to cover the MAA population, it could no longer be determined, for example, "whether in the administration of the MAA program during [the July 1971 to October 1973 period] the State applied the revised standard of eligibility established by the amended State plan to all eligible or potentially eligible individuals," as required under 42 U.S.C. §1396a(a). Grant Appeals Board Decision, *supra*, Appendix at 10a. Finally, we are reluctant to waive Regulation 201.3(g) in this instance lest other states, following New Jersey's example, seek similar retroactive reimbursements for medical services provided to groups not covered, for whatever reasons, under their original Medicaid plans.

D

We have also considered New Jersey's contention that HHS misdetermined the State's MAA income-eligibility standard and therefore imposed a disallowance excessive in amount. We believe this contention to be without merit, for the reasons set forth by the Grant Appeals Board in its decision below. *See* Grant Appeals Board Decision, *supra*, Appendix at 10a.

IV

New Jersey's petition for review will be denied.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX B

Judgment of the United States Court of Appeals for the Third Circuit

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 80-2438

STATE OF NEW JERSEY,

Petitioner

vs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent

ON PETITION FOR REVIEW OF A DECISION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

JUDGMENT

Present: ADAMS, ROSENN and SLOVITER, *Circuit Judges.*

Appendix B

This cause came on to be heard on the record from the Department of Health and Human Services and was argued by counsel October 29, 1981.

On consideration whereof, it is now here ordered and adjudged by this Court that the said Petition for Review be and the same is hereby denied, and it is further ordered and adjudged that the order of the said Department entered August 8, 1980, be, and the same is hereby affirmed.

Costs taxed against petitioner.

ATTEST:

SALLY MRVOS
Clerk

February 5, 1982

Certified as a true copy and issued in lieu of a formal mandate on March 1, 1982.

Test: M. ELIZABETH FERGUSON

Chief Deputy Clerk, United States Court of Appeals for the Third Circuit.

APPENDIX C

Decision of the Departmental Grant Appeals Board of the Department of Health and Human Services

DEPARTMENTAL GRANT APPEALS BOARD
Department of Health and Human Services

DATE: August 8, 1980

SUBJECT: New Jersey Department of Human Services
Docket No. 78-159-NJ-HC
Decision No. 115

DECISION

Background

Title XIX of the Social Security Act (hereafter Act), popularly known as Medicaid, was enacted in 1965 for the purpose of enabling each state, as far as practical under conditions in the state, to provide medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals with insufficient financial resources to meet the costs of necessary medical services. Medicaid is a joint Federal/state program. States initiate, design and operate the programs. The Department of Health and Human Services (formerly Health, Education, and Welfare), through the Health Care Financing Administration (HCFA), approves each State's plan which provides the basis for claiming Federal financial participation (FFP).

People who receive cash assistance under Aid to Families with Dependent Children (AFDC) authorized by

Title IV-A of the Act are automatically covered under Medicaid. Aged, blind and disabled people who receive cash assistance under the Supplemental Security Income (SSI) program authorized by Title XVI of the Act or under state supplementation programs are also automatically covered. However, states can impose Medicaid eligibility requirements on SSI recipients that are more restrictive than SSI requirements. States can also cover certain people not entitled to cash assistance. In all cases, however, the terms and conditions of eligibility must be specified in the State plan which is approved by HHS. Each state determines who is eligible for various benefits within the state. Accordingly, eligibility requirements and benefits available to individuals may vary among the states.

Under the provisions of Section 121(b) of Public Law 89-97 (Title XIX) enacted July 30, 1965, no payment may be made to any State under Title I, Title IV-A, Title X, Title XIV or Title XVI of the Act for medical care and services after December 31, 1969. Thereafter, FFP in vendor payments for medical or remedial care is only available under Title XIX of the Act.

There is evidence that New Jersey was aware of some of the ramifications of participating in Medicaid. A report to the New Jersey General Assembly dated September 10, 1968, prepared by its Committee on Institutions and Welfare (Tab No. 35, Record of Reconsideration) pointed out that the State was obligated to develop a State plan to implement Title XIX or lose Federal funding for medical assistance. The report recognized the differences between "categorically needy," "medically needy," and "categorically related" individuals and how the inclusion of one group in the State plan might require extending coverage to other groups because of the provisions of the law.

The report specifically addressed New Jersey's Medical Assistance for the Aged (MAA) program which is the focus of this appeal. Noting the various options available to the State, the Committee recommended that all MAA recipients eligible for Old Age Assistance (OAA) (Title I) be transferred to that program and that the State continue to provide medical assistance for the remainder at its own expense. The Committee rejected the option of covering all MAA recipients under Medicaid because this would require the inclusion of additional individuals not then receiving MAA, without the benefit of Federal matching funds.

There is also evidence that when State officials were formulating procedures to implement Title XIX, Federal officials were involved in the planning. It appears that both the New Jersey Legislature and State administrators were informed by Federal officials that some recipients of New Jersey's MAA program would not be able to qualify for the OAA program because of income and resources in excess of the eligibility standards (Tab No. 25, Record of Reconsideration). At that time, monthly income of $160 or less would satisfy the standard of need for the OAA program (Division of Public Welfare Circular Letter No. 715, dated November 12, 1969).

New Jersey's Medicaid State Plan, effective January 1, 1970, since its initial submission, covered only the categorically needy, but included the optional categorical group described in 45 CFR 248.10(b)(2)(ii) as eligible individuals. (See State Medical Assistance Manual, effective January 1, 1970, Section C, page 223, Item 3a) (Tab No. 30, Record of Reconsideration).

Appendix C

Regulations at 45 CFR 248.10(b)(2)(ii) permit a state, at its option, to extend Medicaid coverage to a categorically eligible group described as:

> Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan. . . .

During the period from January 1, 1970, through June 30, 1971, New Jersey's Title I, X, and XIV plans, and therefore its Title XIX state plan, provided for the recognition of "special circumstance items . . . essential for the physical health and safety of persons in specified situations" in calculation of recipients' budgets. Thus, individuals with incomes in excess of the basic monthly standard of need, against which applicants' incomes were ordinarily assessed in the course of determining eligibility for benefits, could be eligible for public assistance benefits if their incomes were below the financial limit augmented to include special need items.

New Jersey, however, did not initially make a claim for FFP in paying the costs of medical services rendered to these individuals during the period prior to June 30, 1971. The State, without FFP, paid the costs of care for individuals with incomes over the monthly public assistance need standard, yet insufficient to meet the costs of nursing home care. This group apparently included some persons who actually belonged to the optional Medicaid categorically eligible group as well, and thus should have been covered under the Medicaid Federal cost sharing program.

Appendix C

On July 1, 1971, New Jersey altered its State plan to provide for a consolidated standard or "flat grant." That is, all recognized need items were averaged into single money amounts, which varied only according to family size. Although provision remained in the plan for making needed homemaker services available to individuals or family units already determined to be eligible for assistance, neither the cost of homemaker service or of any other special circumstance item was included as a factor in the process of determining financial eligibility for benefits. The income standard against which institutionalized individuals' incomes were to be compared for purposes of establishing Medicaid eligibility was a set monetary level that remained constant irrespective of any special needs that an individual might have if he were residing in the community.

The State apparently believed that the income limitation was absolute and did not initially request FFP for those individuals in medical facilities whose income and resources exceeded OAA eligibility standards but whose means were insufficient to meet the costs of institutional care. According to the Deputy Director, Division of Medical Assistance and Health Services (Tab No. 17a, Record of Reconsideration), State officials did not become aware of the fact that at least some of the individuals could qualify for Medicaid until late September 1973. After learning that a reasonable fee for homemaking services could be added to the standard of need for institutionalized individuals, New Jersey amended its State plan to provide for this category of beneficiary. The amended State plan was approved by HHS on December 10, 1973, with an effective date of October 1, 1973.

The State included in its Quarterly Statement of Expenditures for the period October 1 through December 31, 1974 a claim for FFP in the amount of $14,842,373 in the costs of rendering services to institutionalized MAA patients whose special needs would have inflated their basic cost of living if they had resided in the community, during the period from January 1, 1970 through October 30, 1973. The Agency informed the State on May 5, 1975, that the claim was being denied, "[a]s New Jersey only covered in its State Plan for Titles I, X and XIV, persons whose income was less than $162 until the Plan was amended in November 1973, it is not possible to claim federal matching prior to that date."

On May 15, 1975, the State requested reconsideration of the disallowance (SRS Docket No. ME-NJ-7501). After considering substantial input from the State and Agency officials, including a conference with the then Acting Administrator on July 1, 1976, the Administrator of HCFA issued a decision on November 22, 1978 which upheld the Regional Commissioner's disallowance of the claim for $14,842,373 for FFP in the State's MAA program for the period July 1, 1971 to September 30, 1973 because under Section 1903(a)(1) of the Act, FFP is allowable solely for costs incurred in rendering medical assistance to individuals covered under an approved State plan. The Administrator did hold, however, that the State could submit a revised claim for the period from January 1, 1970 through June 30, 1971, because the State plan did in fact provide coverage of the institutionalized population upon which the State based its claims.

The State did submit a revised claim with its June 1979 Quarterly Statement for $2,839,237 in FFP for the period from January 1, 1970 through June 30, 1971. It is assumed that this claim has been satisfied and the only amount still in dispute is for the period from July 1, 1971 to September 30, 1973.

Appendix C

This decision is based on the State's application for review dated December 20, 1978 and filed in accordance with 45 CFR Part 16, the Agency's Record of Reconsideration, the Agency's response to the appeal and the State's reply brief.

This case presents two issues on which the decision could turn. The primary argument of the State appears to be that the Agency is estopped from denying New Jersey's claim for FFP because Federal officials provided inaccurate, incomplete or misleading information upon which the State relied to its detriment. The State further argues that at least some of the individuals for whom Federal sharing is being claimed were in fact covered under the State plan.

As has been noted by both parties in submittals to the Board, the events leading to formulation of the State plan and its implementation have become blurred by the passage of time. There does not appear to be a genuine dispute as to the factual content of evidentiary material submitted for consideration, and therefore, there is no need for a hearing under 45 CFR 16.8(b)(2), as was requested by the State. There is, however, disagreement as to the import of the information and the conclusions to be drawn therefrom.

Estoppel

New Jersey alleges that Federal officials not only failed to advise the State that it could increase eligibility standards so as to permit the MAA population to participate in Medicaid but made material misrepresentations of fact and law with respect to the State's rights and options. The State argues that but for Federal officials' incomplete or erroneous advice, New Jersey would have amended its State plan to allow for Medicaid coverage of the MAA population since the State did furnish a full range of services to that group solely at its own expense.

Under cover of a letter dated April 7, 1976 (Tab No. 17, Record of Reconsideration), New Jersey submitted affidavits from various State officials purporting to show that Federal officials did in fact fail to inform and guide the State in formulating its Medicaid Plan. In addition, the letter pointed out that the Medicaid State Plan did provide for coverage of an optional categorically eligible group of individuals who had enough income to meet their needs while institutionalized but not enough to meet their needs outside the facility. It seems, however, that the State did not fully understand the significance of this information with respect to the period from January 1, 1970 through June 30, 1971 because it did not argue that it was clearly entitled to FFP for at least this period of time.

On July 30, 1976 (Tab No. 25, Record of Reconsideration), New Jersey submitted additional material intended to show that Federal officials were aware of the State's erroneous beliefs with respect to the potential eligibility of its MAA population to Medicaid coverage and were responsible, at the very least, for allowing the State to maintain its misunderstanding of Federal requirements.

In response to a legal opinion furnished by HHS's Assistant General Counsel to the Director of the Division of Special Claims (Tab. No. 26, Record of Reconsideration), the State argued (Tab. No. 28, Record of Reconsideration) that it is immaterial whether Federal officials misled the State by statements or silence; the Federal Government was still liable because of its affirmative duty to provide the State with technical and legal advice.

In the State's view, the Agency, as a fiduciary of Title XIX monies, has an affirmative duty to assist the states in developing as inclusive a program as possible with the aid of Federal funds. The State points out that Title XIX is remedial legislation and urges that its provisions be given liberal interpretation in order to fulfill the objectives of the legislation. Further, the State characterizes 45 CFR 248.10(b)(2)(ii) as ambiguous and notes that New Jersey could not be expected to understand and apply its provisions without special guidance from Federal officials. The State argues that by denying the claim for FFP, the Agency thwarts the State's discretion to develop a medical assistance program to meet its needs and undermines the framework of cooperative federalism since the State can no longer rely upon Federal expertise.

The Agency's response to the State's application for review denies that the record established a factual basis for the allegations regarding incorrect or misleading information furnished by Federal officials. The Agency states that even if the allegations were true, the Federal Government would not be estopped from denying New Jersey's claim for benefits. In essence, the Agency argues that the government could not be estopped when acting in its sovereign rather than proprietary capacity. In addition, HCFA proposes that the government could not be bound by its employees' unauthorized representations or by its employees' passive failure to provide information.

Although the record is by no means conclusive as to what occurred during the time in question, it is reasonable to assume that the State was not specifically informed that it could claim FFP for the MAA population under the State plan in effect January 1, 1970 through June 30, 1971. Otherwise, New Jersey would have claimed the Federal share from the outset and retained the provisions of the State plan which granted eligibility to that group. This is not to say, however, that the Board accepts the State's theory that the Agency is estopped from denying payment of the claim for the period from July 1, 1971 to September 30, 1973.

Title XIX of the Social Security Act was carefully considered by both Houses of Congress prior to its passage. The precise language of the statute demonstrates that it was the intent of Congress that each State would determine, within a broad general framework, the extent to which it would participate in the program. Section 1901 of the Act specifies that "[f]or the purpose of enabling each State, *as far as practicable under the conditions in such State* . . ." (emphasis added), to furnish medical assistance and other services, sufficient sums will be appropriated to carry out the purpose of the Title. The instrument evincing the state's degree of participation was to be the State plan for medical assistance (Section 1902 of the Act). While the state was charged, as a condition of Federal participation in funding, with formulating and implementing the State plan, the Secretary of HHS was given the responsibility to insure that the State plan, as formulated, conformed to the statutory requirements (Section 1116 of the Act) and to determine whether the State plan, as implemented, complied with statutory requirements (Section 1904 of the Act). Thus, the Federal role in administering this cooperative program was essentially limited to ensuring that the states were acting in accordance with the conditions set forth in the legislation.

Given these circumstances, the Board rejects the theory that Federal officials have a legally enforceable obligation to provide advice and guidance to states regarding the content of State plans. This is particularly true in view of the fact that states are not bound to follow such advice. Federal officials are not privy to the various policy considerations which determine the scope of a State plan and cannot be expected to anticipate problems which might result from the State's implementation of its plan. To the extent that there is a national policy of "cooperative federalism," it is inconsistent to allow a state to shift the responsibility for its errors or omissions to Federal officials and thereby avoid the consequences of its actions.

In the instant case, there is evidence that New Jersey was familiar with the concept of adjusting the standard of eligibility to allow for special circumstances. The State plan in effect in 1970 contained an artfully drafted proviso (Tab No. 17b, Record of Reconsideration) which granted coverage to the MAA population and entitled New Jersey to FFP in the expenditures made for this group. The fact that State officials administering the plan may have been misinformed or uninformed would not alter the outcome with respect to its claim for FFP for the period from July 1, 1971 through September 30, 1973. If a state has any doubt whether it is entitled to FFP, it may submit a claim and receive an official Agency determination. Likewise, if a state has a question whether any group may be properly included within the state plan, it may include the group and receive an official

Agency determination whether such inclusion conforms with the statutory requirements. In both instances, there are review and appeal rights which the state may pursue. Thus, even if New Jersey was misinformed, the Board can only conclude that the State was not diligent in protecting its interests.

Federal regulations encourage the states to consult with regional staff when a plan is being prepared or revised. Also, regional staff is expected to initiate discussions with the state on clarification of significant aspects of the plan (see 45 CFR 201.3(a)(b)). This in no way, however, shifts the responsibilities of the respective parties. The state still must present a comprehensive plan for medical assistance describing the nature and scope of its program and the Agency, on behalf of the Secretary, must determine prior to approval whether the plan meets the requirements set forth in the statutes.

Eligibility of MAA Recipients

The State alleges that institutionalized MAA recipients qualify for "aid or assistance" under the State plan for Title I, X and XIV programs and thus are eligible, in accordance with the provisions of Section 1902(a)(10) and Section 1905(a) of the Act, for Title XIX benefits. The "aid or assistance" which the MAA recipients were eligible to receive was purchased social services, but the State argues that this is sufficient to meet the statutory requirement in that they would have been eligible for financial assistance under another State plan had they returned to the community at large.

The Agency rejected the State's theory that provisions in the State plan for furnishing social services to individuals with special needs was sufficient to qualify the MAA population for Title XIX participation. The Agency stated that the controlling regulation, 45 CFR 222.55, which stipulates that the State may elect to provide services to certain specified subgroups of people, applied to former or potential recipients of financial assistance. The fact that the MAA population would be potentially eligible to participate in various programs intended to provide special social services was insufficient.

The Board does not agree with the State's interpretation of Section 1902(a)(10)(A) of the Act. Under 45 CFR Part 222, as in effect during the critical period, various mandatory provisions for all service programs under Titles I, IV, X, XIV and XVI of the Act are set forth and include certain mandatory services which must be made available to all persons eligible under the State plan. In addition, the regulations provide that states may provide a wide range of optional services. The optional provisions include in addition to homemaker services such services as home delivered meals, companionship services, education services related to consumer protection and money management, assistance in obtaining recreational and educational services and services for such groups as alcoholics. If the State's theory is correct, recipients of any of these services would qualify for medical assistance under Title XIX because they received "aid and assistance" under one of the appropriate Titles of the Act.

In the opinion of the Board, when Section 1902(a)(10) speaks of making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under Titles I, IV-A, X, XIV or XVI of the Act, it is referring to the "categorically needy."

Any other result would require as a matter of law that medical assistance be furnished to anyone receiving optional services under the State plans of any of the other Titles. Judging from the evidence of record, New Jersey intended to restrict its plan to the categorically needy (See Tab No. 35, Record of Reconsideration).

Retroactivity of Plan Amendment

New Jersey urges that the revision of its State plan in the final calendar quarter of 1973 be applied retroactively to July 1, 1971. In support thereof, the State argues that there is no statutory proscription against retroactive amendment. Noting that 45 CFR 201.3(g) stipulates that the effective date of a new plan or a plan amendment that makes new groups eligible for assistance or services provided under the approved plan may not be earlier than the first day of the calendar quarter in which it was submitted, the State cites *Smale & Robinson* v. *United States* for the proposition that although Federal administrators may not waive substantive requirements of a statute, they do have the power to waive regulatory requirements as to procedure and form which are shown to be intended solely for administrative convenience which should not bar retroactivity of the amended State plan.

The Board does not agree. While it is true that Title XIX of the Act does not specifically prohibit retroactive application of a State plan, it appears that Congress intended an approved State plan as a requisite for FFP. Section 1902(a) of the Act requires a State plan to include a variety of provisions which must be applied contemporaneously with the service provided. Obviously, these provisions cannot be enforced retroactively. In this case, for example, the Agency would have no way of knowing if the State during the period in question granted MAA benefits to all individuals who met the standards set forth in the December 1973 amendment to the State plan. The State itself probably has no way of knowing if this was done. While the Agency could determine the Federal share of the cost for the institutionalized MAA population, it could not determine whether in the administration of the MAA program during the period from July 1, 1971 through September 30, 1973 the State applied the revised standard of eligibility established by the amended State plan to all eligible or potentially eligible individuals. If it did not, such actions would constitute failure to comply substantially with various provisions of Section 1902(a).

Thus, 45 CFR 201.3(g), which limits the effective date of the amended State plan, is not a mere procedural matter promulgated for administrative convenience. It is an important portion of the Agency's process in fulfilling the statutory obligation to determine whether the State plan was administered in compliance with the provisions of Section 1902(a)

Income Eligibility Level

The Board has also considered the State's contention that the income eligibility level for MAA recipients should be $170 rather than $162. This contention is apparently based on the fact that during the time in question, the State allowed to those individuals requiring assistance in day-to-day living arrangements, $150 per month for boarding home care plus $20 per month as a personal allowance. It is not clear, however, how this can be related to a determination of eligibility for the MAA population. The section of New Jersey's Financial Assistance Manual which is cited clearly limits expenditures for designated classes of eligible individuals rather than sets forth eligibility standards. It is assumed that the State relies on Section 131.1 of the Manual which allows $170 for individuals requiring boarding home care rather than Section 131.2 of the Manual which allows $220 for individuals requiring services in an Intermediate Care Facility because it wants to invoke the provisions of 45 CFR 248.10(b)(2)(ii). This will not do, however, in the absence of provisions in the State plan which specifically provide for special needs when determining eligibility. It is the absence of such provisions which is cause of this controversy. The State cannot bootstrap allowances for eligible individuals to exceptions in the established eligibility standards for individuals not otherwise eligible.

Finally, the State also asserts that the Agency's final decision failed to include $139,317 attributable to MAA recipients for the period July 1973 through September 1973, representing FFP disallowed for five State mental hospitals resulting from adjustment of interim per diem rates to a final approved rate. It appears, however, that the State raised this claim for the first time in its application for review. The $14,842,373 which was the amount originally in dispute was identified on New Jersey's Quarterly Statement of Expenditures as "MAA claims for institutionalized patients 1/70-10/73." The supporting worksheets do not indicate that any of this amount was for adjusted rates. If the State wishes to present a claim for additional FFP, it must do so in accordance with the pertinent regulations and Agency policy. The Board, in accordance with 45 CFR 16.91, does not have jurisdiction over this subsequent claim and will not consider it at this time.

Conclusion

There is no dispute regarding the central fact in this matter. New Jersey did not include coverage under its State plan for the period from July 1, 1971 through September 30, 1973 for a portion of its aged, institutionalized citizens, referred to throughout this decision as the MAA population. Likewise, there is no dispute that the State could have properly claimed FFP for services rendered to members of this group had the State plan continued to provide them coverage. The State has urged the Board to apply the equitable remedy of estoppel because of the alleged failure of Federal officials to properly perform their duty. Although there is some dispute as to the Federal officials' role in the formulation, administration and amendment of the State plan, the Board does not believe it is necessary to resolve this issue. The Board bases its decision on the conclusion that Title XIX of the Social Security Act, as a condition of Federal financial participation, places sole responsibility for formulation and implementation of the State plan upon the State. The role of the Agency vis-a-vis the State is to ensure that the State plan is in conformance with Title XIX and that it is administered in compliance therewith.

The Board also finds that the State failed to establish that the State plan provided coverage for at least a portion of the MAA population during the period from July 1, 1971 through September 30, 1973.

Accordingly, the decision of the Administrator of the Health Care Financing Administration dated November 22, 1978, is sustained with respect to the denial of the claim for FFP for the period from July 1, 1971 through September 30, 1973.

Frank L. Dell'Acqua

Robert R. Woodruff

Donald G. Przybylinski, Panel Chairman

APPENDIX D

Letter Decision of Leonard D. Schaeffer, Administrator, Health Care Financing Administration, Department of Health, Education and Welfare

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

(SEAL)

Health Care Financing Administration
Washington, D. C. 20201

Office of the Administrator

Mrs. Ann Klein
Commissioner
Department of Human Services
135 West Hanover Street
Trenton, New Jersey 08625

Nov. 22, 1978

Dear Mrs. Klein:

RE: ME-NJ7501

This letter is to convey to you my decision to uphold the former Regional Commissioner's disallowance of $14,842,373 for Federal financial participation (FFP) in payments for the State's Medical Assistance for the Aged (MAA) program for the period January 1, 1970, through September 30, 1973, but to allow the State to submit a revised claim for FFP under the Medicaid program for the period from January 1, 1970, to June 30, 1971.

My decision is supported by substantial evidence in the record and is based on the findings of fact and conclusions of law set forth below.

Appendix D

Background

Regulations at 42 CFR 448.10(b)(2)(ii)* permit a state, at its option, to extend Medicaid coverage to a categorically eligible group described as:

> "Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan."

The language "needs outside the facility according to the appropriate State plan" has been interpreted by the Secretary of Health, Education, and Welfare (HEW) to refer, not only to basic needs such as food, clothes, and shelter, but also to special needs arising from the Medicaid applicant's physical or mental condition, such as needs for attendant or homemaker services.

New Jersey's Medicaid State Plan, effective January 1, 1970, has, since its initial submission, covered only the categorically needy, but has included as eligible individuals the optional categorical group described in 42 CFR 448.10(b)(2)(ii). (See State Medical Assistance Manual, effective January 1, 1970, Section C, page 223, Item 3a). (Attachment A, Item 30)

During the period from January 1, 1970, through June 30, 1971, New Jersey's title I, X, and XIV plans, and therefore its title XIX State plan, provided for the recognition of "special circumstance items" . . . "essential for the physical health and safety of persons in specified situations" in calculation of recipients' budgets. Thus, individuals with incomes in excess of the basic monthly standard of need, against which applicants' incomes were ordinarily assessed in the course of determining eligibility for benefits, could be eligible for public assistance benefits if their incomes were below the financial limit augmented to include special need items.

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* These regulations formerly appeared at 45 CFR 248.10(b)(2)(ii).

Therefore, the optional categorial group of institutionalized individuals who would have been eligible for public benefits if they left institutional care included individuals with incomes in excess of the standard of need for the title I, X, and XIV programs, but who would have had special needs if residing in the community.

New Jersey, however, did not initially make a claim for FFP in paying the costs of medical services rendered to these individuals during the period prior to June 30, 1971. The State, without FFP, paid the costs of care for individuals with incomes over the monthly public assistance need standard, yet insufficient to meet the costs of nursing home care. This group apparently included some persons who actually belonged to the optional Medicaid categorically eligible group as well, and thus should have been covered under the Medicaid Federal cost sharing program.

On July 1, 1971, New Jersey altered its State plan to provide for a consolidated standard or "flat grant." That is, all recognized need items were averaged into single money amounts, which varied only according to family size. Although provision remained in the plan for making needed homemaker services available to individuals or family units already determined to be eligible for assistance, neither the cost of homemaker service or of any other special circumstance item was included as a factor in the process of determining financial eligibility for benefits. The income standard against which institutionalized individuals' incomes were to be compared for purposes of establishing Medicaid eligibility was a set monetary level, that remained constant irrespective of any special needs that an individual might have if he were residing in the community.

Effective October of 1973, the State again amended its Medicaid State Plan to reinstate recognition of homemaker services in making determinations of eligibility for medical assistance. Subsequently, the State submitted to HEW a retroactive claim for FFP in the costs of rendering services during the period from January 1, 1970, through September 30, 1973, to certain institutionalized individuals, whose special needs would have inflated their basic costs of living if they had resided in the community.

Regional Commissioner's Position

The former Regional Commissioner, in a letter dated May 5, 1975, disallowed the State of New Jersey's retroactive claim in the amount of $14,843,373 for the period January 1, 1970, to September 30, 1973. The disallowance related to costs of services rendered under the State's Medical Assistance for the Aged (MAA) program.

The original disallowance was made on the basis of the Commissioner's conclusion that the MAA population covered by the State's retroactive claim was composed of individuals ineligible for Medicaid benefits under New Jersey's State Plan for the relevant time period. Consequently, the State's claim for FFP in paying the costs of services provided to this recipient group was appropriately denied.

Upon subsequent reassessment of the facts of the case, however, the position of the Regional Commissioner has been modified.

At the time of the original disallowance, the Regional Commissioner had overlooked the fact that the special needs provisions were contained in the relevant State plan until New Jersey introduced the "flat grant" in 1971. Realizing this fact, the Commissioner recommended that the Administrator allow the State's retroactive claim for the period from January 1, 1970, to June 30, 1971, since, under the applicable State plan and regulations, a claim relative to that period would apparently have been allowable.

The Regional Commissioner has also concluded that the State's elimination in 1971 of the special needs provisions as factors determinative of eligibility for benefits, and the consequent preclusion of Medicaid coverage of part of the optional category of persons described in 42 CFR 448.10(b)(2)(ii), was the result of a mistake on New Jersey's part. The Commissioner has suggested that the State be permitted to correct this "mistake" by making its October 1973 reinstatement of the special needs provisions retroactive to July 1, 1971, thus making it possible to support New Jersey's retroactive claim for the July 1, 1971, to September 30, 1973, period under 42 CFR 448.10(b)(2)(ii).

State's Position

The State has raised the threshold issue of whether its claim is appropriately handled according to the administrative procedures set forth in 45 CFR 201.14. New Jersey contends that the provisions of this regulation, effective August 18, 1975, are inapplicable in this case where the initial letter of disallowance was dated May 5, 1975. The State asserts in addition, that it was not advised of its right to request a reconsideration, as provided for under 45 CFR 201.14(c).

In support of its retroactive claims, the State asserts that HEW Regional Office officials failed to advise the State that the MAA population, including the institutionalized group falling into the "optional" category because of special needs, could have been transferred to the title XIX program as of January 1, 1970. As a result of this failure, New Jersey, unaware that certain members of the optional category were, in fact, covered by Medicaid, neglected to claim FFP in the properly allowable costs of care for these individuals.

The State further contends that its failure to include the requisite special needs provisions in its State plans, as amended in July of 1971, resulted from faulty or incomplete advice from HEW. New Jersey claims to have been misled by the Regional Commissioner or HEW officials at that time with respect to the State plan revisions necessary to provide Medicaid coverage to the MAA population. The State asserts that it would not have amended its State plans to eliminate special circumstance items as factors in eligibility determinations if it had received correct information from the agency with regard to the impact of such amendments upon the scope of Medicaid coverage.

Findings of Fact

1. The State's Medical Assistance Manual effective during the January 1, 1970, to June 30, 1971, period provided

for medical assistance coverage to "categorically needy" persons only. This included recipients of benefits under the OAA, AB, APTD, and AFDC programs, as well as institutionalized individuals not receiving financial assistance under these programs, but who would be eligible for such assistance if residing outside of a medical facility. Thus the optional categorical group described in 42 CFR 448.10(b)(2)(ii) was covered by Medicaid under the New Jersey plan.

2. The New Jersey title I, X, and XIV plans during the period from January 1, 1970, to June 30, 1971, provided for the coverage of individuals whose income exceeded the basic standard of need, but who, because of necessary expenses related to certain special needs vital to their existance in the community, were considered in need of, and financially eligible for, public assistance benefits.

3. The optional categorically eligible group described in 42 CFR 448.10(b)(2)(ii), and covered under the New Jersey Medicaid State Plan for the period from January 1, 1970, to June 30, 1971, included institutionalized persons whose incomes exceeded the standard of need for existing public assistance programs, but whose special needs in a community setting would have established their eligibility for benefits under such programs.

4. The Financial Assistance Manual, (Transmittal number 71-6) replaced the New Jersey Categorical Assistance Manual, as of July 1, 1971, and established a consolidated standard of need, or "flat grant" for public assistance programs under titles I, IVA, X and XIV. The effect of this amendment was the elimination of "special circumstance items" as criteria for determinations of eligibility for public assistance program benefits.

5. Because of the 1971 amendments to New Jersey State Plans for titles I, X, and XIV, there did not exist under the Medicaid State Plan for the period from July 1, 1971, to September 30, 1973, a group of institutionalized individuals who, if residing in the community, would have been categorically eligible for Medicaid because of their special needs. Accordingly, the plan did not provide for Medicaid coverage of any such group.

6. The State has persistently contended that its elimination of Medicaid coverage of the portion of the optionally eligible group involved in this case, i.e. institutionalized persons whose anticipated special needs in a community setting might have been determinative of their categorical eligibility, was the result of inadequate or incorrect advice from HEW. The factual accuracy of this claim, however, is not established in the record of reconsideration.

7. The record of reconsideration for the retroactive claim period January 1, 1970, to June 30, 1971, does not specify the amounts expended for medical assistance to the MAA population under the special needs provisions of the categorical State plan. Moreover on a field review conducted on April 19, 1978, by personnel of the Regional Office and the Central Office of HEW, it was determined that a number of the SNF's and ICF's in which these people were residing may not have met Federal standards for participation. Therefore, the provider status must be determined prior to the acceptance of a revised claim for the period of January 1, 1970, to June 30, 1971. (Attachment A, Item 33)

8. The April 19, 1978, field review revealed the fact that the State included more than the MAA recipients in

the retroactive claim which resulted in the claim being overstated for the entire disallowance period. (Attachment A, Item 33)

Applicable Statutes and Regulations

Section 1903 of the Social Security Act

45 CFR 201.3(g)

45 CFR 205.5(b)

45 CFR 248.10(b)(2)(ii)

45 CFR 248.10(d)

Conclusions of Law

Regulations now appearing at 45 CFR 201.14 establish administrative procedures through which the agency is obligated to afford to the states participating in the Medicaid program review of challenged disallowance of FFP claims. Prior to the promulgation of these regulations, neither hearings nor any other formal procedures were required in the context of denials of FFP under Medicaid. (See 40 FR 25600, June 17, 1975.) The regulations setting forth the reconsideration process represented a codification of procedures which, although initially not legally mandated, had been found to be the most fair and efficient means of reviewing challenged disallowances. (Id.)

If the State is correct in its contention that the provisions of 45 CFR 201.14 do not have binding effect in this case, the consequence is that the administrative procedures provided for therein are not legally mandated. It is difficult to see, however, how the State's interests could possibly be prejudiced by an administratve decision to afford the State more extensive and formal review of its claims than is actually required by law. Thus the application of the procedures described in 45 CFR 201.14 to this case, whether legally required or not, does not deprive the State of any legal rights. On the contrary, it serves only to afford New Jersey access to a remedial administrative procedure, designed to protect the State's interests in claims for FFP. Accordingly, it is proper to utilize the procedures provided for in 45 CFR 201.14 in the course of administrative review of this case.

A State may properly claim FFP in the costs of rendering services to persons eligible for Medicaid benefits under its approved State plan and the relevant law and regulations. During the period from January 1, 1970, to June 30, 1971, the New Jersey State Plan did in fact provide coverage to the institutionalized population upon which New Jersey bases its claim. Therefore, the State was entitled, under the provisions of 42 CFR 448.10(b)(2)(ii), to FFP in the otherwise allowable costs of care rendered to this group. Accordingly, the State's retroactive claim for the Federal share of these costs is valid, and should be allowed.

Nevertheless, under the Medicaid Statute, FFP in the costs of institutional care is available only for care rendered to eligible individuals in facilities that meet certain Federal standards. (See 1905(c) and (d), of the Social Security Act.) The State's claim for FFP in costs incurred in the pre-July 1971 period are invalid insofar as they represent costs of services provided by facilities that had not achieved provider status under Federal standards for provider participation.

With regard to the second period covered by New Jersey's claim, i.e. July 1, 1971, to September 30, 1973, the Administrator is not legally authorized to recognize the State's claim. Under 1903(a)(1) of the Social Security Act, FFP is allowable solely in costs incurred in rendering medical assistance to individuals covered under a State's approved Medicaid plan. Since the State plan in effect during this second period did not cover as eligible for Medisaid benefits the institutionalized population on behalf of which New Jersey claims FFP, that claim may not legally be paid by the Federal Government.

The fact that, in this case, FFP is not authorized by law cannot be altered by the State's arguments that it was misled or misinformed by Federal officials. It is by no means clear from the record of reconsideration that the State's elimination from its State plan of a segment of the previously eligible institutionalized group was the result of reasonable reliance on material misrepresentations by agency officials. Even if these allegations were substantiated, however, the Federal Government's participation in the costs claimed by New Jersey in this case would not be compelled. On the contrary, the Administrator would still lack authorization under law to allow FFP in costs of services to individuals not covered by the applicable State plan. (A more complete discussion of the legal issue raised by New Jersey's claims of misrepresentation appears in Attachment B.)

The State's claim cannot be rendered valid by a retroactive amendment of its Medicaid State Plan. Under regulations at 45 CFR 205.5(b), the effective date of a State plan amendment can be no earlier than the first day of the quarter in which it is submitted.

In summary, FFP in costs associated with the "special needs" MAA population while it was excluded from Medicaid State Plan coverage is not authorized by law. Consequently, the claim for costs of rendering services to this population during the July 1, 1971, to September 30, 1973, period must be disallowed.

Decision

On the basis of the findings of fact and conclusions of law set forth above, I have determined that the decision of the former Regional Commissioner to disallow $14,842,373 for FFP in Medical Assistance for the Aged must be upheld.

The State may submit a revised claim for the period January 1, 1970, to June 30, 1971, for recipients determined to be eligible under the requirements of the categorical assistance plan. Documentation in support of the claim should include the maximum income standard in effect from January 1, 1970, through June 30, 1971, which took into consideration an applicant's special needs and evidence which indicates that a determination was made that the individual's income was greater than the basic standard and did not exceed the income standard which took into consideration that individual's special needs. The claim cannot include any expenditures for services not included in the title XIX State plan or claims for recipients in any facility which did not meet Federal and State standards for provider participation.

Amendments to 45 CFR 201.14 published in the *Federal Register,* Vol. 43, No. 44, March 6, 1978, (copy enclosed) transferred to the Chairman, Departmental Grant Appeals Board, the authority to make the final determination on reconsideration of disallowances. Accordingly, a copy of this decision and a copy of the complete reconsideration record is being furnished to the Board. Under the revised provisions of 42 CFR 401.14, you may, by written notice filed with the Executive Secretary of the Board within 30 days after mailing of this decision, elect to have the reconsideration governed by 42 CFR Part 16. Such written notice should be sent to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health, Education, and Welfare, Room 3760, North Building, 330 Independence Avenue, S.W., Washington, D.C. 20201, with a copy to this office.

If the matter is handled under 45 CFR 201.14 instead of 42 CFR Part 16, the conference which you requested under 42 CFR 401.14(d)(7), may be held by the Chairman of the Board or one or more Board members he designates. Request for such a conference should be addressed to the Executive Secretary of the Board and should be filed within 30 days after mailing of this letter.

Sincerely yours,

Leonard D. Schaeffer
Administrator

Enclosures

cc: Regional Medicaid Director
Region II

Regional Administrator, HCFA
Region II

Appendix D

Acting Director
Division of Financial Services

Executive Secretary
Departmental Grant Appeals Board

APPENDIX E

Statutory and Administrative Provisions Involved

Federal Social Security Act.

Section 1902 (a)(10)(A) and (B) of Public Law 89-97, previously codified at 42 USC § 1396 a (a)(10)(A) and (B) (current version, 42 USC § 1396a (a) (10)(A) and (C)).

A State plan for medical assistance must—

> "(10) provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI; and—
>
> "(A) provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan—
>
> "(i) shall not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such State plan, and
>
> "(ii) shall not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals not receiving aid or assistance under any such plan; and
>
> "(B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such

State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide—

"(i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care and services, and

"(ii) that the medical or remedial care and services made available to all individuals not receiving aid or assistance under any such State plan shall be equal in amount, duration, and scope;

except that the making available of the services described in paragraph (4) or (14) of section 1905(a) to individuals meeting the age requirement prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages;

* * *

Regulations of the Department of Health, Education and Welfare.

45 C.F.R. §248.10 (coverage and conditions of eligibility for medical assistance)

Appendix E

(a) Definitions—When used in this part:

(1) The term "categorically needy" refers to an individual who is receiving financial assistance under the State's approved plan under title I, IV-A, X, XIV, or XVI of the Social Security Act or is in need under the State's standards for financial eligibility in such plan. (See §233.20 of this chapter. See also paragraphs (b) (3) and (4) of this section for individuals who are treated as if they were "categorically needy".)

(2) The term "medically needy" refers to an individual whose income and resources equal or exceed the State's standards under the appropriate financial assistance plan but are insufficient to meet his costs for medical insurance premiums and for necessary medical and remedial care and services recognized under State law but not encompassed in the State plan for medical assistance plus his costs for medical and remedial care and services included in the State plan.

(b) State plan requirements—A State plan under title XIX of the Social Security Act must:

(1) Provide that medical assistance will be available to the following groups of "categorically needy" persons:

(i) All individuals receiving aid or assistance under the State's approved plans under titles I, IV-A, X, XIV, and XVI of the Act; this includes all individuals who (a) are essential persons under the State plan and (b) could be recipients, if the State plan were as broad as permitted for Federal financial participation:

(ii) All individuals under 21 who are or would be, except for age or school attendance requirements, dependent children under the State's approved AFDC plan;

(iii) All persons who would be eligible for aid or assistance under one of the other approved State plans except for any eligibility condition or other requirement in such plan that is specifically prohibited in a program of medical assistance under title XIX of the act.

(2) Specify any other groups of "categorically needy" individuals (not covered by subparagraphs (1) of this paragraph), that will be included in the program. These may include:

(i) Persons who meet all the conditions of eligibility, including financial eligibility, of one of the State's other approved plans, but have not applied for such assistance.

(ii) Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan. Children may be included in this group if they would meet all conditions of eligibility under the State's AFDC plan if outside the facility.

Appendix E

45 C.F.R. §201.3 Approval of State plans and amendments.

The State plan consists of written documents furnished by the State to cover each of its programs under the Act: Old-age assistance (title I); aid and services to needy families with children (part A of title IV); services to aged, blind, or disabled (title VI); aid to the blind (title X); aid to the permanently and totally disabled (title XIV); aid to the aged, blind or disabled (title XVI); or medical assistance (title XIX). The State may submit the common material on more than one program as an integrated plan. However, it must identify the provisions pertinent to each title since a separate plan must be approved for each public assistance title. A plan submitted under title XVI encompasses, under a single plan, the programs otherwise covered by three separate plans under titles I, X, and XIV. After approval of the original plan by the Service, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted currently so that the Service may determine whether the plan continues to meet Federal requirements and policies.

(a) *Submittal.* State plans and revisions of the plans are submitted first to the State governor or his designee for review in accordance with § 204.1 of this chapter, and then to the regional office. The States are encouraged to obtain consultation of the regional staff when a plan is in process of preparation or revision.

(b) *Review.* Staff in the regional offices are responsible for review of State plans and amendments. They also initiate discussion with the State agency on clarification of significant aspects of the plan which come to their attention in the course of this review. State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance. Comments and suggestions, including those of consultants in specified areas, may be prepared by the central office for use by the regional staff in negotiations with the State agency.

(c) *Action.* The Regional Commissioner exercised delegated authority to take affirmative action on State plans and amendments thereto on the basis of policy statements or precedents previously approved by the Administrator. The Administrator retains authority for determining that proposed plan material is not approvable, or that a previously approved plan no longer meets the requirements for approval, except that a final determination of disapproval may not be made without prior consultation and discussion by the Administrator with the Secretary. The Regional Commissioner or the Administrator formally notifies the State agency of the actions taken on State plans or revisions.

(d) *Basis for approval.* Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet, the requirements for approval are based on relevant Federal statutes and reuglations. Guidelines are furnished to assist in the interpretation of the regulations.

(e) *Prompt approval of State plans.* Pursuant to section 1116 of the Act, the determination as to whether a State plan submitted for approval conforms to the requirements for approval under the Act and regulations issued pursuant thereto shall be made promptly and not later than the 90th day following the date on which the plan submittal is received in the regional office, unless the Regional Commissioner has secured from the State agency a written agreement to extend that period.

(f) *Prompt approval of plan amendments.* Any amendment of an approved State plan may, at the option of the State, be considered as a submission of a new State plan. If the State requests that such amendment be so considered the determination as to its conformity with the requirements for approval shall be made promptly and not later than the 90th day following the date on which such a request is received in the regional office with respect to an amendment that has been received in such office, unless the Regional Commissioner has secured from the State agency a written agreement to extend that period. In absence of request by a State that an amendment of an approved State plan shall be considered as a submission of a new State plan, the procedures under § 201.6 (a) and (b) shall be applicable.

(g) *Effective date.* The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted, and with respect to expenditures for assistance under such plan, may not be earlier than the first day on which the plan is in operation on a statewide basis. The same applies with respect to plan amendments that provide additional assistance or services to persons eligible under the approved plan or that make new groups eligible for assistance or services provided under the approved plan. For other plan amendments the effective date shall be as specified in other sections of this chapter.

Appendix E

Regulations of the New Jersey Department of Institutions and Agencies, Division of Public Welfare.

Part I—page 8
Financial Assistance Manual Effective 7/1/71

130. ADULTS IN APPROVED GROUP FACILITIES

(Not Applicable to ADC or AFWP)

131. *Adults in Boarding Homes and Intermediate Care Facilities*

131.1 When it is determined that an eligible adult is in need of extensive personal services on a regular and continuing basis, a room and board living arrangement may be purchased in an Approved Boarding Home for Sheltered Care or in a private family home, other than that of a relative, in which this individual is the only guest requiring some care.

This individual's recognized needs shall include:

a. an allowance for this living arrangement, not to exceed $150. per month; and

b. a monthly personal allowance of $20.

* * *

Part II—page 1
Financial Assistance Manual Effective 7/1/71

200. PROCEDURES FOR DETERMINING AMOUNT OF MONTHLY GRANT

201. Form PA-3A

To determine the monthly assistance grant, Form PA-3A WORKSHEET AND AUTHORIZATION

FOR PUBLIC ASSISTANCE, shall be prepared for each eligible unit. All information supporting the data on Form PA-3A must be included in the agency's case record.

Form PA-3A, reproduced on pages 3 and 4, shall be completed as follows:

* * *

d. To determine the amount of assistance, Part II, make the appropriate entries according to the numbers below:

Income:

RSDI .... (1)
Calculated Earned Income .... (2)
Other Income ....(3)

____

____

Total Income .... (4)

Public Assistance Allowance:

Schedule I .... (5)
Schedule II .... (5)
or
Other Living Arrangement
Room/Board ....(6)
Personal Allowance ....(7)
Total Allowance .... (8)
Minus Total Income .... (9)
Adjusted Allowance .... (10)

(1) Enter any payment(s) received from Social Security (RSDI).

(2) Enter amount of calculated earned income, if any, as determined in Part V.

(3) Enter any other income to the eligible unit, identifying the source in the space provided, such as contributions from LRRs, pensions other than Social Security, etc. (see Section 323.), and adjustment for eligible member temporarily out of the home, (see Sections 122.-d, and 124.-d).

New Jersey Department of Institutions and Agencies—Division of Public Welfare

* * *

Part II—page 2

Financial Assistance Manual Effective 7/1/71

201.d. (continued)

(4) Total all income.

(5) Enter appropriate public assistance allowance(s) from Schedule I and/or II; *or*

(6) for adults living in group facilities, enter appropriate allowance for living arrangements as identified in Section 131. (for adults receivin purchased care in institutions as identified in Section 132., no amount shall be entered; and

(7) enter personal allowance as appropriate (Sections 131. and 132.);

(8) enter the amount or total of amounts from (5) or the total of (6) and (7).

(9) Enter total income from (4).

(10) Subtract (9) from (8) to determine the adjusted allowance.

e. *The Monthly Grant*

1) In OAA, Da, and AB programs, the adjusted allowance is the amount of the monthly grant.

* * *

Part IV—Page 5

Financial Assistance Manual Effective 7/1/71

* * *

412. *Expenses Incident to Homemaker Service*

412.1 When homemaker service is not available through staff service of the County Welfare Board and is not otherwise available to the eligible unit without cost, homemaker service may be purchased for the eligible unit by direct contractual arrangement and payment (as an administrative/service expense) between the County Welfare Board and the community agency furnishing approved homemaker service or an individual who is mutually acceptable to the eligible unit and the County Welfare Board. Such purchase may be made for a person or persons for whom illness, death or other disruption in normal family living has created problems and for that reason homemaker service (other than

"home health aide" service provided under the Medicaid program) is essential.

Homemaker service shall be provided only for a person(s) who lives alone or as a member(s) of a family group.

412.3 Homemaker service, when purchased, shall be at the most reasonable rate for which the service can be obtained.

Financial Assistance Manual (12/10/73)

130. ADULTS IN APPROVED GROUP FACILITIES (Not Applicable to ADC or AFWP).

* * *

132.1 *An adult whose physical condition is such as to require care in one of the above institutions shall be eligible for such care through the Medicaid program when his total monthly income does not exceed $510.*

* * *

Appendix E

MEDICAL ASSISTANCE FOR THE AGED

Manual of Administration

* * *

3321. *Home Eligibility for Hospitalization and Home Health Care.*

* * *

3312. Income Eligibility for Hospitalization and Home Health Care (Cont'd.)

.2 Single Person

a. Monthly income is $150 or less

Single person whose monthly income is $150 or less has income eligibility.

b. Monthly income is more than $150 but not over $500

Single person whose monthly income is more than $150 but not over $500 has income eligibility. The adjusted income schedule (see Appendix V) shall be used to determine the amount the client shall pay or be obligated to pay for medical services before any payment of medical assistance may be authorized.

c. Monthly income is more than $500

The single person whose monthly income is more than $500 does not have income eligibility.

.3 Married Person

a. Income eligibility of client and/or spouse

When income eligibility for a married person is being determined, the monthly income limitation for income eligibility applies whether one or both of the married persons is applying for hospitalization and/or home heath care.

b. Monthly income is $250 or less

Married client and spouse whose combined monthly income is $250 or less have income eligibility.

c. Combined monthly income is more than $250 but not over $600

Married client and spouse whose combined monthly income is more than $250 but not over $600, have income eligibility. The adjusted income schedule (see Appendix V) shall be used to determine the amount the client shall pay or be obligated to pay for medical services before any payment of medical assistance may be authorized.

* * *

MEDICAL ASSISTANCE FOR THE AGED

* * *

3322. *Income Eligibility for Nursing Home Care*

* * *

.2 Single Person

* * *

b. Monthly income is $210 or less

The single person whose monthly income is $410 or less has income eligibility.

* * *

Appendix E

3322. Income Eligibility for Nursing Home Care (Cont'd)

.3 Married Person

* * *

c. Combined monthly income is $650 or less

The married person whose combined monthly income is $650 or less has income eligibility.

d. Combined monthly income is more than $650.

The married person whose combined monthly income is more than $650 does not have income eligibility.

* * *

315. *EXPENSES INCIDENT TO HOMEMAKER SERVICE*

315.1 *An Allowance for special circumstance, or a vendor payment on behalf of the client for homemaker service may* be recognized for a client when illness, death or other disruption in normal family living has created problems and on the basis of the social and/or medical diagnosis, it is determined that homemaker service is essential.

Opposition

Office - Supreme Court, U.S.
FILED
JUL 22 1982

No. 81-2061

In the Supreme Court of the United States

OCTOBER TERM, 1982

STATE OF NEW JERSEY, PETITIONER
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

ROBERT GREENSPAN
RICHARD OLDERMAN
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 633-2217

QUESTIONS PRESENTED

1. Whether the courts of appeals have jurisdiction under Section 1116 of the Social Security Act, 42 U.S.C. 1316, to review decisions of the Departmental Grant Appeals Board denying federal financial assistance under the Medicaid program for past state expenditures.

2. Whether the federal government may be estopped from denying reimbursement of improper Medicaid expenditures by petitioner because HHS officials failed to provide adequate guidance to petitioner when its Medicaid plan was adopted.

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In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 81-2061

STATE OF NEW JERSEY, PETITIONER

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-32a) is reported at 670 F.2d 1284. The opinion of the Departmental Grant Appeals Board (Pet. App. 35a-52a) is not reported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 33a-34a) was entered on February 5, 1982. The petition for a writ of certiorari was filed on May 4, 1982. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

Section 1116 of the Social Security Act (42 U.S.C. 1316) is set out in pertinent part at pages 6-8, *infra*. Section

1902(a)(10)(A) and (B) of the Social Security Act, as added by Pub. L. No. 89-97, Title XIX, 79 Stat. 345 (42 U.S.C. (1970 ed.) 1396a(a)(10)(A) and (B)), is set out at Pet. App. 67a-68a. Pertinent federal and state administrative regulations are set out at Pet. App. 68a-81a.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. (& Supp. IV) 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see, *e.g.*, *Schweiker* v. *Hogan*, No. 81-213 (June 21, 1982), slip op. 2. To participate in the program, a state must develop a Medicaid plan that is consistent with the requirements of Title XIX and federal regulations. 42 U.S.C. (& Supp. IV) 1396, 1396a. See *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 35 (1981). Following approval of the plan by the Secretary of Health and Human Services (see 42 U.S.C. 1396a(b); see also 42 U.S.C. 1316(a)), the state is entitled to federal financial assistance for providing medical care to eligible individuals who are covered by the state plan. 42 U.S.C. (& Supp. IV) 1396, 1396b(a).

Section 1902(a)(10) of the Social Security Act establishes the basic scope of the Medicaid program. 42 U.S.C. 1396a(a)(10); see *Schweiker* v. *Hogan*, *supra*, slip op. 2. Participating states are generally required to offer Medicaid coverage to all persons who receive cash benefits under one of the categorical assistance programs (*i.e.*, the "categorically needy"). 42 U.S.C. 1396a(a)(10)(A); see *Schweiker* v. *Gray Panthers*, *supra*, 453 U.S. at 37-39.[1]

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[1] When the Medicaid program was established there were four state-administered categorical assistance programs. Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to the Blind

Although participating states generally are not required to offer Medicaid coverage to any other group of people, there are a number of optional coverage groups. See, *e.g.*, *Herweg* v. *Ray*, No. 80-60 (Feb. 23, 1982), slip op. 3. After the Secretary's initial approval of a state Medicaid plan, the state may modify the scope of its program by amending the plan so long as the amendments do not render the plan inconsistent with federal requirements. See generally 42 U.S.C. 1396c. Any proposed amendment of a state plan must be submitted to the Secretary for approval. At the state's option, the amendment may be reviewed pursuant to the procedure specified for initial approval of the plan. See 42 U.S.C. 1316(b); 45 C.F.R. 201.3, 201.4, 201.7.

2. Since January 1970, when its Medicaid plan became effective, petitioner has offered medical assistance to the categorically needy and to one optional coverage group, namely, institutionalized individuals who are ineligible for cash assistance because of the amount of their incomes but who would be eligible for such assistance if

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(AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.;* Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.;* Aid to Families with Dependent Children (AFDC), Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.* In 1972, Congress replaced the state-administered cash assistance programs for the aged, blind, and disabled with a completely federal program called Supplemental Security Income for the Aged, Blind, and Disabled (SSI), Title XVI, 42 U.S.C. (& Supp. IV) 1381 *et seq.;* the AFDC program is still administered by the states and is only partially funded by the federal government. See *Schweiker* v. *Gray Panthers*, *supra*, 453 U.S. at 37-38. The old categorical assistance programs are still in effect in Guam, Puerto Rico, and the Virgin Islands. See Pub. L. No. 92-603, Title III, Section 303(a) and (b), 86 Stat. 1484.

they left the institutions (see 42 C.F.R. 435.211). Between January 1970 and June 1971, the standards of financial eligibility under petitioner's Old Age Assistance (OAA) program varied depending on the applicant's "special needs" (*e.g.*, the need for a housekeeper). Thus, an individual whose income exceeded the basic income standard was nonetheless eligible for cash assistance under petitioner's OAA program if his income was less than the basic income standard plus the cost of satisfying his special needs. Petitioner modified its OAA financial eligibility standards so that between July 1971 and October 1973, an individual was only eligible for assistance if his income was less than the basic income standard; for those people who were eligible for cash assistance under this more restrictive standard, petitioner provided for their special needs in-kind. After July 1971, petitioner also provided services under its OAA plan to some individuals who were ineligible for cash assistance. Effective October 1973, petitioner changed its OAA financial eligibility standards to take into account the applicant's special needs as it had done between January 1970 and June 1971.[2]

In February 1974, petitioner sought reimbursement of nearly $15 million under the Medicaid program (Pet. App. 9a). Petitioner claimed federal reimbursement for part of the cost of providing medical care between January 1970 and October 1973 to institutionalized individuals whose income was greater than the basic OAA income standard but less than the basic income standard plus the cost of providing for their special needs if they had left the institutions. The Administrator of the Health Care Financing Administration agreed that petitioner was entitled to federal financial assistance for providing medical care to these people between January 1970 and June 1971. Because these people would have been eligible for cash assistance under petitioner's OAA plan in effect during that period if they had left their institutions, and because petitioner's Medicaid plan provided for coverage of this optional coverage group, the Administrator concluded that petitioner was entitled to reimbursement under the Medicaid program. *Id.* at 10a, 62a. On the other hand, under petitioner's OAA plan in effect from July 1971 through October 1973, these people would not have been eligible for cash assistance even if they had left the institutions. Therefore, the Administrator concluded that they were not covered under petitioner's Medicaid program in effect at that time, and petitioner was not entitled to federal financial assistance for providing medical care to them during that period. *Id.* at 10a, 63a.[3]

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[2] Petitioner's OAA program was superseded by the SSI program, which became effective on January 1, 1974.

Petitioner sought review of the Administrator's decision before the Departmental Grant Appeals Board. 42 U.S.C. 1316(d); 45 C.F.R. 201.14; 45 C.F.R. Part 16, App. A. The Board upheld the Administrator's decision (Pet. App. 35a-52a).

3. Petitioner sought judicial review of the Grant Appeals Board's decision in the United States Court of Appeals for the Third Circuit. Following the analysis set forth in its prior decision in *New Jersey* v. *HHS*, 670 F.2d 1262, 1268-1277 (1981) (*New Jersey I*), the court of appeals held that it had jurisdiction to review the decision of the Grant Appeals Board under Section 1116 of the

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[3] The Administrator also rejected petitioner's claim that the October 1973 amendment to its OAA plan should be applied retroactively (Pet. App. 63a). See 45 C.F.R. 201.3(g).

Social Security Act, 42 U.S.C. 1316. Pet. App. 11a-17a. The court acknowledged (*id.* at 14a) that none of the bases of jurisdiction specified in Section 1116 was "explicitly" involved in this case. Nonetheless, the court concluded that it had jurisdiction to review the decision of the Grant Appeals Board because of the substance of the underlying dispute between petitioner and HHS. The court of appeals then rejected each of petitioner's claims on the merits and affirmed the decision of the Grant Appeals Board (Pet. App. 20a-32a).

ARGUMENT

1. Under 28 U.S.C. 1254, this Court's jurisdiction is limited to review of "[c]ases in the courts of appeals." See *Nixon* v. *Fitzgerald*, No. 79-1738 (June 24, 1982), slip op. 9; see also *Liberty Mutual Insurance Co.* v. *Wetzel*, 424 U.S. 737, 740 (1976). A threshold issue presented in this case, therefore, is whether the court of appeals correctly concluded that it had jurisdiction under Section 1116 of the Social Security Act, 42 U.S.C. 1316, to review the decision of the Grant Appeals Board. The court of appeals' ruling on the jurisdictional issue is contrary to the plain language of the statute and is likely to produce confusion and unnecessary litigation. We do not seek review of the court's holding on this point for two major reasons: (1) the court correctly rejected each of petitioner's contentions on the merits; and (2) the Third Circuit is the only court of appeals that has addressed whether Section 1116 authorizes direct review of any administrative decisions other than those specified. If, contrary to our submission, the Court grants the petition in this case, we will brief the jurisdictional question.

The plain language of Section 1116 is dispositive of the jurisdictional question (emphasis added):

(a) Determination of confirmity [*sic*] with requirements for approval; petition for reconsideration; hearing; time limitations; review by court of appeals

(1) *Whenever a State plan is submitted to the Secretary by a State for approval* under subchapter I, VI, X, XIV, XVI, XIX [Medicaid], or XX of this chapter, or part A of subchapter IV of this chapter, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such subchapter. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) *Any State dissatisfied with a determination of the Secretary under paragraph (1)* of this subsection *with respect to any plan may*, within 60 days after it has been notified of such determination, *file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such subchapter*. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a *final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section* 304, 604, 804, 1204, 1354, 1384, 1396c [Section 1904 of the Act], or 1379b of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of

> the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28.
>
> * * * * *
>
> (b) Amendment of plans
>
> For the purpose of subsection (a) of this section, *any amendment of a State plan approved under subchapter* I, VI, X, XIV, XVI, XIX [Medicaid], or XX of this chapter, or part A of subchapter IV of this chapter, *may, at the option of the State, be treated as the submission of a new State plan.*
>
> * * * * *
>
> (d) Items covered under other subchapters; disallowance
>
> *Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter* I, VI, X, XIV, XVI, or XIX, XX of this chapter, or part A of subchapter IV of this chapter, *shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.*

The statute describes only three bases of direct review in the courts of appeals and (in subsection (d)) clearly distinguishes the denial or disallowance of federal financial assistance for particular past expenditures. The Secretary's disapproval of either a state Medicaid plan or a plan amendment is subject to direct review in an appropriate court of appeals, as is the Secretary's decision to terminate future payments under Section 1904 of the Act, 42 U.S.C. 1396c.[4] Decisions denying reimbursement for past expenditures are not subject to direct review in the courts of appeals.

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[4] Section 1904 of the Social Security Act, 42 U.S.C. 1396c, provides:

Consistent with the statutory scheme, HHS regulations prescribe distinct procedures for considering new state plans (45 C.F.R. 201.3, 201.4, 201.7; see generally 45 C.F.R. Part 213), and plan amendments (45 C.F.R. 201.3(f), 201.4, 201.6, 201.7; see generally 45 C.F.R. Part 213), for taking action to terminate future payments under Section 1904 of the Act (45 C.F.R. 201.6, 201.7; see generally 45 C.F.R. Part 213), and for making disallowance decisions (45 C.F.R. 201.14; 45 C.F.R. Part 16 & App. A). Having concluded (Pet. App. 14a) that this case did not involve any of the specified bases for direct review under Section 1116, the court below should have dismissed the petition for review for lack of jurisdiction. Petitioner's challenge involved no more than an objection to the denial or disallowance of federal financial assistance for particular past expenditures. Whatever the reason for the denial of federal reimbursement of expenditures, Section 1116 does not authorize direct review in the courts of appeals.

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

The Third Circuit appeared to recognize the correctness of this conclusion (Pet. App. 12a; citation omitted):

> Where the Secretary makes no finding with respect to plan-disapproval or plan-nonconformity, but instead simply "disallows" a state's request for reimbursement of "any item or class of items" deemed by the Secretary not to be eligible for federal financial participation under the Act, a petition addressed to a court of appeals would appear not to be in order. Rather, in such a situation, an aggrieved state's proper recourse, according to HHS, is first to request administrative reconsideration of the disallowance, and then to seek judicial review in a federal district court.

Nonetheless, the court of appeals held that, "when considering the section 1316 jurisdictional question, [we refuse] to be bound by the label that the Secretary attached to the agency's administrative activity" (Pet. App. 13a). In the court's view, " '[t]he administrative determination about which New Jersey complains would appear to resemble more a finding of overall noncompliance with federal requirements,' reviewable under section 1316(a), than 'a technical, audit-connected shortcoming,' appropriate for resolution under section 1316(d)." *Id.* at 14a, quoting from *New Jersey I*, *supra*, 670 F.2d at 1275.

The court of appeals' reading of the statute is not only inconsistent with its plain language, but also unworkable. Any failure to comply with the requirements of the Act that increases expenditures and is sufficient to justify proceedings under Section 1904 will almost invariably provide grounds for a disallowance of past expenditures as well. Similarly, a proposed plan amendment that increases expenditures and is inconsistent with the Act will provide grounds for a disallowance if it is implemented. Thus, as the court of appeals itself suggested (Pet. App. 14a, quoting *New Jersey I*, *supra*, 670 F.2d at 1275;

internal quotations omitted), *any* disallowance except one based upon "a technical, audit-connected shortcoming" or a "mere 'clerical' problem" (Pet. App. 16a n.12) would, under its view of the statute, be subject to direct review in the courts of appeals.[5]

The court below offered no reason for disregarding the statutory scheme, and there is none. Furthermore, the court's heavy reliance on *Texas Department of Public Welfare* v. *Califano*, 556 F.2d 326 (5th Cir. 1977), cert. denied, 439 U.S. 818 (1978), is misplaced. On appeal from a *district court* judgment, the Fifth Circuit held that the Secretary had used the wrong procedures in considering the state's claim for federal reimbursement of expenditures under a state welfare program. The question whether a court of appeals could have reviewed the Secretary's decision directly under Section 1116 in such circumstances was not presented.

2. Petitioner contends that the Secretary is estopped from denying its claim for Medicaid reimbursement.[6] The

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[5] Because of the vagueness of the Third Circuit test for determining jurisdiction, any state that seeks judicial review of a Grant Appeals Board disallowance decision would be wise to file petitions for review in both the appropriate district court and the court of appeals to avoid the prospect of finding out too late that what it believed to be a disallowance dispute was actually a compliance or conformity dispute. A number of states recently have done just that. See, *e.g.*, *Minnesota* v. *Schweiker*, No. 82-1164 (8th Cir.); *Connecticut* v. *Schweiker*, No. 82-4023 (2d Cir.); *Illinois* v. *Schweiker*, No. 82-1175 (7th Cir.); *Massachusetts* v. *Departmental Grant Appeals Board*, No. 82-1403 (1st Cir.).

[6] The effective date of Old Age Assistance plan amendments that expand the scope of coverage under the plan cannot be earlier than the first day of the calendar quarter in which the amendment is submitted for approval. 45 C.F.R. 201.3(g); see also note 3, *supra*. The amendment to petitioner's OAA plan that modified financial

court of appeals correctly rejected this argument in an opinion on which we rely (Pet. App. 20a-31a). As the court concluded (*id.* at 26a), "[e]ven if it were clear as a legal matter that estoppel could be invoked against the federal government, we would still be obliged to conclude that [petitioner] does not make out a compelling estoppel claim, given the particular facts present here."

Between July 1971 and October 1973, petitioner's OAA financial eligibility standards did not take into account an applicant's "special needs." Pet. App. 21a, 39a, 55a-56a. During that period, therefore, an applicant for OAA benefits whose income exceeded the OAA income limits was ineligible for cash assistance, whatever his special needs might have been. In addition to the coverage of the categorically needy required by the Medicaid statute (42 U.S.C. 1396a(a)(10)(A)), petitioner's Medicaid plan has since its inception provided for coverage of one optional group: institutionalized individuals who would be eligible for cash assistance under one of the categorical assistance programs (*e.g.*, OAA) if they left their institutions. See generally 42 C.F.R. 435.211; *Herweg* v. *Ray*, No. 80-60

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eligibility standards to take into account an applicant's special needs (as petitioner had done before July 1971) was submitted for approval in November 1973, and approved in December 1973. Pet. 11. In accordance with 45 C.F.R. 201.3(g), the amendment was effective as of October 1973. Petitioner did not request approval of the amendment retroactive to July 1971 and did not seek review of the October 1973 effective date.

In support of its claim for Medicaid reimbursement, petitioner argued that the 1973 amendment to its OAA plan should be "applied retroactively to July 1971," notwithstanding its October 1973 effective date. See Pet. App. 48a; see also *id.* at 31a-32a. But 45 C.F.R. 201.3(g) would have barred approval of the amendment retroactive to July 1971. Moreover, even without regard to 45 C.F.R. 201.3(g), the amendment by its own terms became effective October 1973.

(Feb. 23, 1982), slip op. 3.[7] For example, between July 1971 and October 1973, institutionalized individuals whose income exceeded the OAA cash assistance standards were also ineligible for assistance under petitioner's Medicaid plan, whatever their special needs might have been had they left the institution.

Petitioner asserts, however, that the federal government should be estopped from denying reimbursement of the cost of providing medical services to individuals who were plainly ineligible for Medicaid benefits under the plan in effect at the relevant time.[8] Conceding (Pet. 17)

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[7] One of the predecessors of the regulation cited in the text is set out at Pet. App. 70a. To the extent relevant here it authorized the states to provide Medicaid coverage to:

> Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan.

See 45 C.F.R. 248.10(b)(2)(ii) (1972).

[8] Petitioner does not appear to contest the court of appeals' affirmance of the agency's conclusion that the OAA financial eligibility standards in effect between July 1971 and October 1973 did not take into account any special needs an applicant may have had. Nor does petitioner challenge the court's holding (Pet. App. 21a-22a) that because the OAA financial eligibility standards in effect at the relevant time did not take into account special needs, those needs were also irrelevant for purposes of Medicaid eligibility. In short, petitioner concedes at least for purposes of argument in this Court that its claim for reimbursement is for medical services provided to individuals who were ineligible for assistance under its Medicaid plan in effect between July 1971 and October 1973.

In any event, that point is not subject to serious dispute. Contrary to petitioner's apparent suggestion (Pet. 21-22 n. **), the services provided to individuals under petitioner's OAA program are immatethat "no fraud or ill motives can be ascribed to the federal government," petitioner argues that HHS officials failed to provide adequate guidance to petitioner in formulating its Medicaid plan. According to petitioner, this failure constitutes a breach of "statutory obligation" and "affirmative misconduct" sufficient to estop the federal government. More specifically, petitioner claims (Pet. 24) that HHS officials failed to explain that the method for determining financial eligibility in the OAA program should also be used in the Medicaid program to determine whether an institutionalized individual would be eligible for OAA benefits if he left the institution. See note 7, *supra*. Because of HHS' failure to explain this "obscure" point, petitioner contends that it did not realize that changing the financial eligibility standards under its OAA program would also have an impact on its Medicaid program.[9]

None of HHS' alleged omissions prevented petitioner from reading the statute and relevant regulations. See *Federal Crop Insurance Corp.* v. *Merrill*, 332 U.S. 380 (1947). On its face the governing regulation (Pet. App. 70a) indicates that the OAA financial eligibility standards are controlling for Medicaid purposes. That regulation at least suggests that if special needs are taken into account in determining OAA eligibility, those same needs should be taken into account in determining whether an in-

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rial. The only relevant inquiry is whether the institutionalized individuals were receiving aid or assistance or "would [have been] eligible for financial assistance" (Pet. App. 20a) under the OAA plan. See also *id.* at 49a-51a.

[9] Contrary to petitioner's assertions (Pet. 7, 9, 24), it does not appear that any of the information given by HHS officials was inaccurate. See Pet. App. 27a.

stitutionalized Medicaid applicant would be eligible for OAA benefits if he were not in an institution. In any event, it is clear that HHS' omissions did not cause petitioner to take action or fail to take action that petitioner could not have corrected. See *Schweiker* v. *Hansen*, 450 U.S. 785, 789 (1981); *Montana* v. *Kennedy*, 366 U.S. 308, 314-315 (1961). At any time during the relevant period, petitioner could have amended its OAA financial eligibility standards (as it finally did effective October 1973) and would have become entitled to Medicaid reimbursement for providing medical assistance to individuals who would have been eligible for OAA benefits under the modified standard upon leaving their institution.

There is no basis for petitioner's assertion that HHS officials' failure to advise petitioner of the Medicaid significance of the OAA financial eligibility standard constituted a breach of any statutory obligation. At most, petitioner has asserted that HHS officials "negligently" failed to provide all of the information potentially relevant to petitioners' Medicaid program. See *INS* v. *Hibi*, 414 U.S. 5, 8-9 (1973). As in *Schweiker* v. *Hansen*, however, that conduct falls far short of anything that would raise a serious question whether the federal government is estopped from insisting upon compliance with valid regulations.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

Rex E. Lee
Solicitor General

J. Paul McGrath
Assistant Attorney General

Robert Greenspan
Richard Olderman
Attorneys

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